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Doing Drugs Policy: Narratives of Participation in the Development of a Critical Drug Theory

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Declaration

I declare that this thesis was composed by myself, that the work contained herein is my own except where explicitly stated otherwise in the text, and that this work has not been submitted for any other degree or professional qualification except as specified.

Part of this work (a shortened version of chapter 7) has been published as Ross, A. (2020) *Drug Users as Stakeholders in Drug Policy.* In Buxton, J. Burger, L., Margo, G. (Ed's) 'The Impact of Global Drug Policy on Women: Shifting the Needle', Emerald Publishing.

A small percentage (2%) of the work is taken from different academic submissions to the University of Edinburgh. These submissions were a dissertation for an LLB with Honours entitled 'The Criminalisation of Recreational Drug Users: Questions of risk and morality (2008), and 'Analysing Qualitative Data Course Assessment (2017), for a course taken during the PhD.

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Abstract/Lay Summary

Introduction

It is a well-documented and a historical fact that human beings have ingested certain substances in order to change their perceptions of reality for centuries, if not millennia (RSA, 2007; Nutt, 2015; Bancroft, 2009, ch.2; Bennet & Holloway, 2010, ch.2). However, it was not until the beginning of the twentieth century that a serious effort was made to outlaw certain drugs for use other than medical, through international and national conventions and frameworks. The regulation of certain drugs has resulted in a policy framework to manage the governance of drug policy interventions, and it is the development of this framework, and participation of drug consumers (policy stakeholders) within this framework that the thesis explores, and critiques.

Methods

Using interpretive policy analysis as an overarching research design, the thesis explores and critiques the development of the concept of 'problem drug use', and seeks to unpick this concept using Carol Bacchis 'What's the Problem Represented to Be' (WPR) approach (Bacchi, 2009). In doing so it highlights the master narratives framing both drug use, and drug user participation within policy development, in Scotland. Furthermore, as a result of using the WPR approach to analyse the data, a new critical theory entitled critical drug theory (CDT) is developed. This theory sits alongside other critical theories such as critical race theory, by focussing on the narratives of silenced or marginalised.

Results

The narratives surrounding drug use define the process by which the participation of stakeholders is incorporated into policy making. More specifically, the narratives of drug harm and the medico/legal structures which surround problematic drug use mean that participation is focused on a small section of the drug using population, namely problematic drug users. This focus is, in part, a result of systemic narratives that have been used to justify policies and practices which disproportionately affect those whose ethnicity, social class, gender, religious, ideological and political viewpoints do not fit into the dominant narrative.

Critical drug theory is grounded in critical thought with the underlying premise that the foundations of drug policy, national and international, are based on ideological reasoning that is often used to suppress and silence those who seek to challenge the status quo. Subjecting policies to critique and critical evaluation, such as research into the impact drug laws have on individuals and society (as opposed to the impact drug *use* has), should be advocated, along with public engagement on the complexity of drug use, pleasure and harm.

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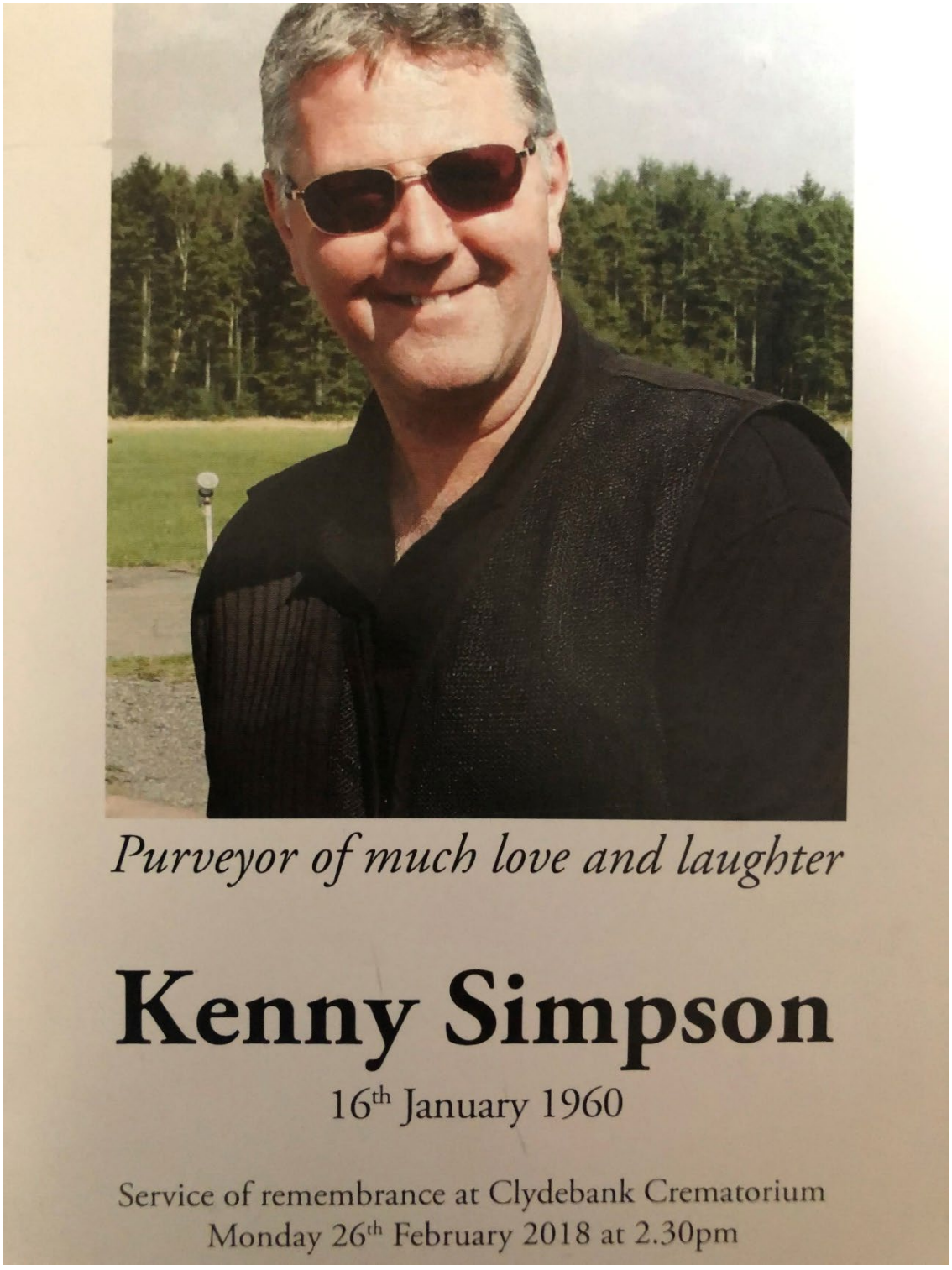
This thesis is dedicated to Kenny Simpson.

"*I never judge anybody on how they are presented, everybody's got their stories to tell, I just don't think there is acknowledgment of that. I think there needs to be more of a caring agenda and common sense approach to drugs*."



Obituary written by myself for Kenny Simpson for SDPC website:

Kenny Simpson worked for the police most of his life, latterly as a civilian running the Statement of Opinion Unit for Police Scotland. He was a champion for sensible drug policy and increasing dialogue and trust between the different institutions and communities responsible for drug policy in Scotland. He represented the middle ground – not pro legalisation but keen to see reform in order to improve the lives of problematic substance users in Scotland. I knew Kenny for a short time, but what I did know of him I enjoyed immensely. Kenny was a participant of the Scottish Drug Policy Conversations since its inception, and always provided a balanced, thoughtful but passionate voice on a range of drug policy issues. I recently interviewed him for my research on narratives within Scottish drug policy communities. Kenny was passionate about leaving a legacy and making sure there was an institutional memory about the changes in drug policy. "*You know one day I'll drop off the radar, I'll probably go and do something drug related somewhere, but you know who becomes the go to person*?"

In recent years Kenny was involved in many different groups and often spoke at debates on drug policy. He was not an advocate of legalisation but only because he thought it hid the real issue which is opiate abuse:

> *"But see the whole legalisation issue for me, that's a backburner. For me there's wider issues than legalising it. You're never going to legalise heroin ever, and heroin's the issue. And I've said that to Mike (from SDPC), I'm fed up with the Police looking at other things when we've got people dying. And if we don't try and go public and raise that agenda, you know it's like the elephant in the room, for Scottish Government, for Police Scotland, for addiction services, for NHS, all these people are dying and it's like [whistles] nobody bothers. It's just another heroin user. It's like 'aye there was 4 heroin deaths this morning, aye well what else is new'. I think that's a tragedy. You know, if there were 4 fatal road accidents every day, and that's a strap line that the media have picked up: there are more drug deaths than there are fatal road accidents'. You know, if there was 4 fatal road accidents every day you'd have police initiatives, you'd have traffic department out there and they'd be on the telly…"*

And fundamentally this is why he continued to be involved in the police and other groups dedicated to drug policy issues: he wanted dialogue and sensible drug policies which actually address the tragedy of drug deaths and doesn't shy away from looking at radical options. He was pragmatic and a copper through and through, always ready with words of wisdom and encouragement. I – and many others- will miss the chats, his advice and down to earth common sense approach to life, and my heart breaks for his close friends and family. Gone far too soon, I feel it is our duty now to continue his legacy of encouraging respectful dialogue and meaningful

engagement amongst those in the drug policy world and beyond. Rest in Peace you kind and compassionate man.

Acknowledgements

I started this PhD journey in 2014. During that time I moved house 3 times, raised two children from 1 and 2.5 years old to almost 7 and 8.5 years old, and recovered from a life threatening lung infection which saw me hospitalised for a month. It is safe to say that without certain people in my life, this PhD would never have come to fruition.

So firstly I would like to thank my partner, William Molleson, who, despite our ups and downs, supported me tirelessly through this process. My children, Lewis and Elliot, who put up with mummy needing to leave home for several days at time to 'write my book', and who witnessed my occasional melt-downs at the pressure this, and other life circumstances put on me. A huge thank you to my mum, Barbara Bryan, who provided childcare, emotional and financial support, and an unending stream of love and admiration for what I was doing. She also gave me the skills I needed to navigate life, which served me well including during the PhD. My gratitude also goes to my dad, Neil Ross, and his partner Mitsie, who also provided endless childcare, support and encouragement throughout this process, especially when I was seriously ill.

Another family, my partners, must be thanked too. Sue Nuttgens, my partners' mother has been amazing throughout the last 6 years. She also helped out with childcare, financial support and emotional support when it all got too much, and Will's dad, John Molleson, who constantly encouraged me to continue, and provided financial support to help me get this final push done without the stress of a full-time job. My gratitude.

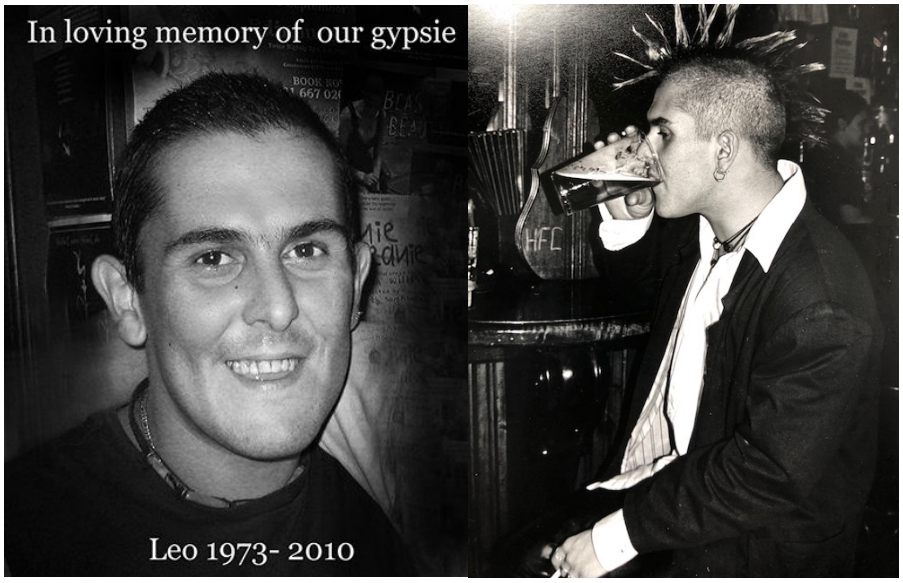
A major emotional support has been my close friendship group, who have provided spaces for me to stay, space for me to moan/chatter about the stress of doing the PhD, and in some cases provided childcare and financial support to help me cover difficult periods. So Chandra Mather, thank you for being my star sister, who I can turn to no matter what, and who has seen me grow from a wee girl wanting a family and a 'real' job, to a professional woman. To Jannica Honey, my partner in crime and friend since my early clubbing days, the deep love and honest support I receive is invaluable. To Aisha Khan, and Olivia Furness, two of my oldest friends from school, who also partied hard with me in my twenties, and have been part of my journey. And finally to Jem le Lievre, my best pal who I stayed with lots and discussed the deeper aspects of philosophy and conscious altering, always good chats. To you all I say a huge thank you.

Then there are the academic supports without which I would not be here. Firstly my supervisors Oliver Escobar and Angus Bancroft. I was concerned at the beginning to the PhD that I may have problems with my supervisors, as issues with them formed a large part of our PhD induction.

However, I feel I had the best, most inspiring and supportive supervisors I could ever have hoped for. I used to go for meetings with my supervisors and come out feeling like a newly chipped diamond. I feel like they were able to understand what I was trying to explain, and chipped away at the rough outside to reveal the shining core inside. Their constant support, frequent contact, and insightful and gentle nudging's in the right direction, allowed me to grow as a researcher and an academic. I cannot thank you enough.

I also must thank some additional staff. Richard Freeman from the Academy of Government, who, despite my slightly radical ideas, took me on, supported the SDPC and facilitated many of the sessions. I didn't always find it easy to work with him, but I know he valued what I was doing, and his support gave me the platform which enabled the development of SDPC. Thank you. I also want to thank John Sturrock, of Core Solutions, who despite commanding a good salary for mediation work, agreed to facilitate several sessions ad hoc, and our development as a group was better for it. Thank you. I would also like to thank the IT team at the University of Edinburgh. It may seem silly, but without them I would have struggled with many of the programmes, broken computers, weird IT issues and general IT knowledge. It has been amazing to be part of an organisation that I can take my IT issues to immediately and have them fixed! I will miss that.

And finally I wish to thank Leonel Cardoso (Kalkito). Leo was my first adult partner, true love, and a 'chaotic and hedonistic drug user'. He introduced me to worlds I would never have accessed had it not been for his heroin dependency and extreme drug use. Despite us separating we stayed in touch until he died 6 years later at the age of 35, of Hepatitis B resulting in multiple organ failure. Yet it is in his memory that I took on drugs policy. His life and his death are what spurred me to action, believing that he would still be alive today if it were not for the current drug policy agenda. His family over the years have been incredibly supportive of my journey and I wish to thank them: Leonel Cardoso Snr, Ricardo and Maria Graca Soeiro. So, to our wee gypsy, rest in peace and see you on the other side.



Leonel Cardoso Photos by Anna Ross

Prologue

Reflections of a Drug User: Coming Out and Coming Here

"It was a driech and drizzly November afternoon and the clouds hung heavy over Edinburgh Castle. As I trudged the dreary streets the weather reflected my mood: grey, despondent and heavy with tears. I was 20 years old, a hardened clubber with 5 years of partying under my belt, but I had just discovered the man I loved, and had agreed to marry, was a heroin addict. I knew nothing about heroin addiction. My illegal drugs of choice at that age were amphetamines, magic mushrooms, cannabis, and above all, ecstasy (MDMA).

I started taking illegal drugs early. By the age of 13 I had tried my first joint and was a regular tobacco smoker and cider drinker. By 15 I was taking amphetamine with the punks and getting into techno music. My initiation into ecstasy happened on New Years eve 1995/96. I had made sure I had a gram of base speed (pure amphetamine) for the evening, and my friends and I found an afterparty at an abandoned house in the center of Edinburgh. However, when it got time to get stuck into the speed I found to my horror that I had lost it. Not to worry said a friendly host, we have pills called California Sunrises (ecstasy), ever tried them? I had not, but true to my inquisitive and risk taking personality I was keen to. From there I spent the next 8 years indulging in different mind expanding substances, with periods of what some would term 'problematic use' interspersed. It was during this time that I met and fell in love with a Portuguese man called Kalkito. We partied hard and loved hard, but 1 year into the relationship it transpired that Kalkito had been a heroin addict since he was 14, and he had come to Scotland to get away from his addiction. Unfortunately it did not work, and this is how, at the age of 20, I found myself wandering the streets of Edinburgh seeking advice and support for myself and my partner.

As I trudged up Cockburn Street having left the local council offices after a disheartening conversation with a council officer on the help available to heroin users, I looked up and saw a sign. A big glowing sign saying 'Crew 2000 Take Drugs Seriously'. Seriously? I thought as I stared at the sign. Behind the sign the windows showed a warm glowing shop, and people who looked like me hanging out near the back, making me feel safe. I stepped into the shop searching for support, and came out the shop having signed up to volunteering for them on a monthly basis, and the rest is history, as they say.

Crew 2000 frontage. Photo by Crew2000

A Cut Above

SCOTLAND ON SUNDAY · 16-APRIL-95

Crew 2000 is a different kind of drug agency. Their leaflets tell it like it is and their workers really know their A, Bs and Es – not to mention the difference between hardbag and hardcore. This month they open an advice shop in central Edinburgh. Coleen Anderson investigates

Taking Es, trips, spliff, speed and jellies is against the law but you might be doing it anyway, or you probably know someone else who is. Drugs can be dangerous – the deaths at Hanger 13 last year proved that – but was it the drugs or just the combination of circumstances, or overheating maybe, that caused the fatalities? Was the E pure or was it mixed with rat poison or some other nasty substance? And how do you find out?

It's hard to get any sensible talk about drugs going when the mere mention of the word often causes panic and hysteria. It's a bit like sex education – we all need it but there's precious little around that's frank enough and actually deals with reality. Sometimes just asking for information about drugs raises the suspicion that you're on a slippery slope to degradation and death, but not asking means you stay ignorant.

Crew 2000 know all about these paradoxes – that's why they're there. They believe you have a right to information which is both accurate and credible, and this month they'll be opening a drugs advice shop in the centre of Edinburgh to provide just that – "People were just laughing at the 'Just Say No' stuff," says one of the Crew's workers, Liz Skelton.

Crew 2000 is not a conventional drug agency. It's run by volunteers aged between 16 and 30 – volunteers who know the difference between hardbag and hardcore! It sprang out of the rise in the use of dance drugs and this is reflected in their work. They run a stall at Rezerrection where they distribute leaflets and information, and they're looking at distributing leaflets in other clubs as well as fashion and record shops.

The leaflets they produce aren't just a dry list of dos and don'ts: each features a whacked-out cartoon strip that tells it like it is.

The Crew also distributes leaflets from other credible organisations such as those of the Manchester based "Lifeline". These include titles such as: "How To Survive Your Parents Discovering You're A Drug User" and one about how drugs affect women in particular – "Clare And Jose Get Off Their Cake"! The advice shop will also have a computer with as much information on drugs as they can load into it – video, sound, graphics, the lot. Future plans include a regular publication and they would also like to see organisations similar to Crew 2000 set up in other parts of Scotland to cater for local situations.

The Crew thinks keeping close to what's actually happening on the streets and in the clubs is important. "A lot of people working in the drugs field don't really know what they're talking about," says one of the volunteers, Graeme. "It's a two way thing," adds Liz. "We get information from people who are out there taking drugs – the idea is that if we hear about a new drug going around we can get information about possible dangers out to as many people as possible."

The members of Crew 2000 are more likely to be dressed for the dancefloor than in the white coats of healthcare professionals. Credibility is the key as good information won't make any difference if the people who are taking drugs, or are thinking about doing it, don't read it. Crew 2000 want you to make up your own mind and they're there to give you the information you need.

Further Information

If you like the sound of what Crew 2000 are doing and want to help or if you just want more information about what drugs do to you and how to prevent problems, then contact the Crew at:
32 Cockburn St, Edinburgh
EH1 1PB
0131 220 3404

Article of the opening of Crew. Photo by someone at crew, image from Crew.

The reason I tell this story is that the help I found led to where I am now, writing this PhD, engaging in policy formation, advice and activism. My understanding of reality has been shaped and formed by my interaction with drug-using communities, and the drugs themselves. And it is Crew 2000 who set me on the path of drug policy, a path that has combined both personal and professional engagement with multiple and disparate illegal drug-using communities.

Crew 2000 is a drug harm reduction charity set up in 1992 by a group of ravers. As the rave scene matured there was an increasing number of different drugs, music and venues to choose from. With this came an increase in production and use of ecstasy in particular, and multiple batches from multiple sources meant multiple variations and no real knowledge how to take them safely. As one interview participant involved in drug policing at the time told me, the largest amount he had ever come across up until the mid '90's was 100 tablets. By the end of the '90's they were getting busts up to 10's/100's of thousands of tablets. Crew 2000 was set up by ravers for ravers, or anyone who used psychoactive drugs. They provided, and still provide, harm reduction advice at music festivals, clubs, pubs and through their drop-in shop on Cockburn Street in Edinburgh. At the time I joined it was still very much run by ravers/clubbers, and we were peers to those we were helping. Our chill out tents at festivals were havens for those who had over indulged, or indulged the wrong thing! Off shift the volunteers partied like our peers, which gave us a credence within the scenes that all other harm reduction agencies (such as there were) did not have. Peer to peer, with a motto of 'some do some don't, some will some won't', we shared our harm reduction advice with love.

For the next 5 years I worked as a peer volunteer at Crew 2000, and from my voluntary experience I moved into paid employment in the support sector. I continued clubbing but my drug using patterns changed. I moved from weekly indulgence to monthly indulgence, although I continued to smoke cannabis daily, and still did until very recently. Through my involvement in the support sector I began working with heavy opiate and alcohol users, many homeless or at risk of homelessness. I had personal experience of the pain heroin addiction can wreak on families and loved ones: I separated from my partner in my early 20's because I was unable to provide the support he needed. He died several years later from multiple organ failure resulting from extreme intoxication and hepatitis B and C infections.

However, apart from my ex-partner, although my peer group were still using drugs regularly, I saw that their use was different in many aspects to those I worked with. Those who accessed the services were using drugs in order to intoxicate themselves beyond comprehension. Many, if not all, had deep trauma from childhood or later years, and the drugs were a way of medicating against this psychological pain. My peer group on the other hand, were mainly using drugs in order to enhance the experience of social gatherings. The more involved I became the more I wondered why it was that drug policy did not reflect the reality I experienced every day. I saw the different

ways that drugs were being used by people, and understood that the reasons for use are complex and varied. I also witnessed the destruction of friends lives when they interacted with the criminal justice system. The following story is about an old friend of mine, yet it is not unique, and I have met several families and individuals who have suffered a similar fate.

> *"In 2001 a good friend of mine was jailed for 6 years having been found guilty of intent to supply ecstasy and cannabis. James (not his real name) had been dealing cannabis for years, always to friends and always in small amounts. Through his cannabis contact he was able to get ecstasy pills, and as a result he started buying large batches of pills to supply his friendship group. For some reason, it was never cleared up but we think he may have been grassed (told on) by an informer, his flat was busted on the same day he had picked up his 9 bar (bar of cannabis weighing 9 ounces) and 250 ecstasy tablets. He was sentenced to 6 years and would get out in 3 with good behaviour. When he went into prison he was a young, good looking man whose only drug vice was using cannabis and ecstasy. When he came out he was a haggard, despondent heroin addict. The trauma he experienced in prison never left him. I was unable to reconnect with him as a friend because our lives had drifted far apart, and the last time I saw him several years ago he had lost all his teeth, was still using heroin, and had serious mental health issues."*

It is these, and numerous other little stories that pepper this thesis, that help shine a light on how my reality is shaped by these experiences. Everyone has these similar vignettes, especially within the broader Scottish drug and alcohol scenes, and they combine to make narratives that guide how we view the world, how we interpret our experiences, and for this research how we form opinions on drug use and drug policy responses. Importantly, it is the meaning we attach to our experiences that guide how we react, but meaning is subjective, and one of the hurdles in developing policy responses that encompass such a myriad of different experiences - and meanings - is finding common meanings through the elicitation and exploration of shared narratives.

A Word on Language

Throughout this thesis there are terms that I use which are subject to much debate. It is important therefore that I outline some of these terms, in order to clarify how I use them.

The first word is 'problem'. This word is used constantly, in both the drug policy community and the thesis. In both it is used to describe the focus of drug policy and drug user themselves, by using the terms 'problem drug/substance use' and 'problematic drug/substance user'. The concept of a 'problem' or 'problematic' is extremely vague, and dependent on individual constructions on what these terms actually mean: one person's problem is another person's paradise! Carol Bacchi (2009, 2015, 2016, 2018) has interrogated this problem paradigm and I use her analytical tool 'What's the Problem Represented to Be' (WPR Approach) in this thesis.

However, in doing so I must also address my own use of the term 'problem'. For example, Bacchi states that:

> *'…in the WPR approach, governments do not react to problems that are presumed to be self-evident. Rather, they are seen to be involved in the creation or production of "problems" as particular sorts of problems, with particular parameters, causes, effects, and remedies. There is no suggestion of manipulation in this proposition; rather, it is a description of the way in which policies do their work…'* (Bacchi, 2018, 5).

Bacchi suggests shifting the focus to problematisations *within policies*, that is, the focus on a particular 'problem' reveals what is implicit in the construction of that 'problem'. Bacchi pulls heavily on Foucault's genealogical archaeology (Foucault, 1986; Bacchi, 2018) and his emphasis on examining the forms of problematisations within studied phenomena.

While elements of this thesis explores the problematisation' within policies, another aspect is the use of the term 'problem drug use', and 'problematic drug users' to describe the kinds of drug use and users that is the focus of much of drug policy. There is no universal definition of what constitutes 'problem drug use' (Chatwin, 2018, 137-138), however institutions and countries have tended to define it as harms stemming from injecting drug use. For example, The UN Office of Drugs and Crime (UNDOC) state that: "*While there is no established definition of problem drug users, they are usually defined by countries as those that regularly use illicit substances and can be considered dependent, and those who inject drugs*" (UNODC, World Drug Report, 2011). The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) defines it as "*Injecting drug use or long duration/regular use of opioids, cocaine and or amphetamines*" (EMCDDA, European Drug Report 2017). The Scottish Government develop this definition a bit further to define 'problem drug users' as: "*a category of people who will be experiencing or causing social, psychological, physical, medical or legal problems because of their drug use. They are likely to be in touch with drug treatment services, although many will not*" (Scottish Government, 2008, 12). They initially state that the focus is on opioid and benzodiazepine use (Ibid, 1), but the definition leaves the possibility of other non-injecting or opioid based use to be considered 'problem drug use'. This concept forms a core aspect of the critique in this thesis, and I explore and build on this in chapters 4 to 6. It should be recognised however that the term 'problem' is not value neutral, and wherever possible I shall highlight how this impacts the research or knowledge contributions of the thesis.

The other term is 'knowledge'. In this chapter I have explored how meaning is developed using narratives and stories, and how an individual's background knowledge and experience influences the way in which they view reality. Furthermore I have set out that I look to use the concept of subjugated knowledge as described by Foucault, when using both my own experience, and the experience of the participants. However, the concept of knowledge in social research, and

particularly in policy, encompasses a vast array of different viewpoints (c.f. Radaelli, 1995; Freemand & Sturdy, 2014). What constitute knowledge is therefore difficult to pin down, although generally speaking it is '*taken to include information, ideas and arguments, as well as well-tested beliefs, and should encompass law as well as professional and academic knowledge*' (Freem and & Sturdy, 2014, 3; Radaelli, 1995, 161). For the purpose of this thesis I use the term to describe both experiential knowledge (information and understanding gained from personal experience) and the wider concept of how knowledge is generated.

A further note is needed in regards the concept of harm reduction. Drug harm reduction is the use of initiatives such as needles exchanges, advise on taking drugs safely, drug checking, drug consumption rooms, and other initiatives that seek predominantly to reduce the harm from taking drugs. As a policy tool it has been in use in Scotland from around the mid 1980's, although it came to prominence at the end of the 1980's and early 1990's in response to concerns around the spread of HIV through injecting drug use, and the increase in psychoactive drug use at raves and outdoor festivals. Although a major part of drug policy in Scotland, it receives very little attention in this thesis, and the main reason for this is it did not show up often in the data. I have therefore spent very little time exploring or critiquing this concept except where it appears in the data, for example during the 1990's rave scene in chapter 5.

A final important explanation is needed of what I mean by 'drug policy communities'. Throughout this thesis I refer to the drug policy community, and communities. I use both the singular and plural, which may be confusing but speaks to the wide range of actors involved in drug policy in Scotland. For clarity, when I use the term 'community' I am referring to the fairly small pot of policy actors in Scotland who are directly involved in the policy making process. When I use the term 'communities' I am referring to the small group of practitioners, but also the wider stakeholder groups that cannot be merged into one 'community' because they represent diverse and often diverging ideas about what drug policy actually is.

PART ONE

Preparing the Ground

In part 1 of the thesis I set out the political and policy backdrop of the research, and explore the literature surrounding narratives, dialogue and policy in order to highlight the research gap addressed by this thesis. Chapter 1 starts us off by setting the historical context of drug policy, and the political and policy developments in the UK. The focus of this chapter is the structural framework that governs drug policy, in order to set the scene for the research. Furthermore, it begins to address a core theme in the thesis: that the development of the harm paradigm surrounding drug use has meant a focus on a health based policy that seeks the recovery of 'problem drug users. This focus on health silences those drug consumers that do not fit within the 'problem/harm' paradigm. By shifting focus away from criminal justice interventions, yet still relying on them to support policy, a section of the drug using population fails to be represented in the national strategy. Chapter 2 then explores the concept of narrative in social research, and how narrative analysis can help to provide deeper understanding of complex policy 'problems'. In doing so it highlights the research gap: how participation is carried out, and meaningfully experienced by different policy stakeholders. Chapter 3 is the methods chapters and sets out methodological framework, including the data collected, the different analytical frameworks I use and the process of writing up. My methodology combines multiple different strategies, and in this chapter I set out and clarify how and why I use this approach. An important aspect of the analytical structure is the use of Carol Bacchi's 'What's the Problem Represented to Be' approach (WPR approach, explained in chapter 3). This analytical framework inspired the structure of the thesis, where each chapter explores 1-3 of the analytical questions in order to develop the case for what the 'problem' (drugs) is represented to be in Scottish policy formation. As a result the focus of the thesis is both the master and counter narratives within Scottish drug policy, as well as the representation of the problem.

Part 2 of the thesis encompasses chapters 4-6 and begins to explore the data by developing a historical genealogy of drug policy development in Scotland entitled Historical Legacies. Chapter 4 takes us through the 1980's, entitled the heroin years, and develops the argument that the increase of heroin use, combined with the HIV/AIDs epidemic set the tone for a harm based drug policy focussed on certain communities and certain kinds of drug use. It uses a narrative storytelling structure utilising interview data and documentary analysis to show how the 'harm paradigm' emerged from this period. Chapter 5 looks at the time period from 1990-2008 and is a partially auto ethnographic account of the silencing of non-opiate drug use. I explore my experience of the

drug using communities at the time to highlight how this kind of drug use has been silenced, or side-lined, by policy makers, in addition to showing how developments at a UK level result in narrowing of the focus to 'problem drug use'. Finally chapter 6 uses interview data and documentary analysis to show how Scotland developed the recovery agenda in the early part of the 21st century, and how this impacts on the narratives surrounding drug use and policy formation going forward.

Part 3 of the thesis forms the contributions to the field of knowledge and encompasses chapters 7-9. Chapter 7 takes the data I collected from participant observation with three stakeholder groups, and analyses this engagement using the WPR approach, and narrative analysis. From this a typology of stakeholders is identified, and used as a structure for the policy stories set out in chapter 9. Chapter 8 sets out the theoretical development that this thesis contributes to – critical drug theory (CDT). CDT is an extension of critical theory, and takes inspiration from critical race theory, particularly the use of narrative and storytelling in challenging oppressive and discriminative practice and policy. The last chapter in this part is chapter 9. This chapter develops this focus on storytelling by setting out a series of fictional narratives that explore the both the historical development of drug policy, and the typology of stakeholder engagement. The aim of this chapter is to show how powerful fictionalised stories can be in creating alternative narratives that speak to range of concerns, and may provide the certainty policy makers need in order to enact drug policy reform.

Finally, chapter 10 concludes the thesis by bringing the findings together in narrative format, and gives space for self-reflection on the whole process, and ideas going forward.

Chapter 1

Setting the Scene: Politics and Policy

History and Context of Drug Policy in the UK

It is a well-documented and a historical fact that human beings have ingested certain substances in order to change their perceptions of reality for centuries, if not millennia (RSA, 2007; Nutt, 2015; Bancroft, 2009, ch.2; Bennet & Holloway, 2010, ch.2). However, it was not until the beginning of the twentieth century that serious efforts were made to outlaw certain drugs for use other than medical, through international and national conventions and frameworks.

One of the reasons for the increased regulation and criminalisation of drug use over the past 100 years is the proliferation of many different types of available drugs, for medical and non-medical use, together with the concern by some in the medical profession about the health risks associated with drug use, especially with dependent opiate use at the turn of the twentieth century (Duster, 1970). At the time of the Pharmacy Act 1868, which was designed to regulate the supply of morphine and opiates (South, 2002), drug use appears to have been restricted to alcohol, tobacco, opium (and its derivatives), hashish and cocaine. These substances were taken by many different social groups and use of these substances was not considered particularly harmful, immoral or unusually deviant (Duster, 1970; South, 2002); many of them could be found in household supplies such as cold remedies or Coca Cola.

During the first decade of the twentieth century there were sporadic attempts to regulate and control the supply of opium, such as the Opium Conference in 1909 and Shanghai Conference in 1911, instigated by the USA. The USA had increasingly come under pressure from religious factions and traders concerned about the effect of the opium trade between Britain, China and India; traders felt American trade was being undermined, and religious factions were concerned about the effect of opium addiction on the Chinese and at home. However, the first major move to have a serious effect on the supply of drugs was the Hague Convention of 1912. The Convention tried to establish an international agreement on the restriction of opium to medical use only, and the imposition of criminal sanctions on those found doing otherwise. However, due to the outbreak of war in 1914 it was not taken up by every country; but was later incorporated into the Treaty of Versailles in 1919 under article 295 (South, 2002).[1]

[1] Parts of this section were taken from my Criminology Dissertation 'The Criminalisation of Recreational Drug Users: Questions of Risk and Morality. This was submitted to the University of Edinburgh in 2008 in partial fulfilment of an LLB with honours. It was also used for a research methods essay in 2015.

The USA was one country which met their obligation promptly, and this was done via the Harrison Narcotics Act of 1914. It is argued that the result of this Act was to criminalise whole sections of society (Duster, 1970), because although it outlawed doctors from giving out opiate derivatives for non medical purposes the Supreme Court ruling in *Webb v US (1919)* held that maintaining an addiction did not constitute a medical purpose (Duster, 1970). The result was the eventual alienation of people who had become 'legitimately' addicted to opiates and now found their addiction was criminalised and outlawed. Many of these addicts were Chinese immigrants and it has been suggested that the opiate laws, in Britain at least, were a result of moral panics over "*oriental conspiracies*" (South, 2002; Hari, 2015). This alienation and criminalisation of certain social groups throughout society due to increased drug laws has since been a common feature of what is now known as 'the war on drugs' (Hari, 2015; Manderson, 2005).

Britain fulfilled its treaty obligations in 1914 with the Defence of the Realm Act, and the provisions were further legislated on with the passing of the Dangerous Drugs Act 1920. This latter Act not only outlawed the sale of opium, but included tinctures of cannabis and cocaine and its derivatives. It is speculated that the addition of cocaine to the list was in response to stories of 'crazed' soldiers during World War 1 (Transform, 2008; RSA, 2007). In 1926 the 'Rolleston Committee', set up by Sir Humphry Rolleston, recommended that addiction be treated as a disease and therefore should be regulated by doctors stating that addiction is a "*problem to be solved not a sin to be punished*" (RSA, 2007). This declaration shows us that drug use was not considered to be a moral or criminal issue but rather a medical and social issue that could only be tackled by medical and social solutions. This became known as the 'British position' and was not altered until the 1960s when it came under increasing pressure to conform to an international regulatory position (Stimson, 1987).

From the 1920s to the mid-1960s Britain was relatively unaffected by the hysteria and moral panic surrounding cannabis and heroin use that had gripped America, driven by the Federal Bureau of Narcotics and the now infamous Harry Anslinger (South, 2002; Hari, 2015; Babor et al, 2018). There appears to have been a more gradual and pragmatic approach during this time, although the criminalisation of cannabis and the new crime of possession in an amendment to the Dangerous Drugs Act 1920 in 1928 may have been a result of inflated views of the prevalence of its use and harm (Transform, 2008). The only developments of importance until the mid-1960s was the creation of the Home Office Drugs Branch in 1934 and the Brain Report in 1961 which upheld the findings of the Rolleston Committee and favoured the status quo regarding drug prescription and criminalisation.

However, this comfortable 'British position' was about to change with the influence of the United Nations Single Convention on Narcotic Drugs 1961, the 1971 Convention on Psychotropic Substances and a later addition of the 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. As a signatory to the UN the UK was obligated to implement any

conventions and protocols agreed by the UN bodies. The UN Convention therefore marked the end of domestic control over drug regulation and policy, and by the mid 1970s most major countries had implemented drugs legislation following what is known as the ABC classification system, with A being the most punitive classification and each drug placed within the system "*according to the accepted dangers and harmfulness in light of current knowledge*" (House of Commons Science and Technology Committee, 2006:a).

For decades it has been the conventional wisdom that under these Conventions flexibility in drug control measures was not possible. However, in recent years have been a swathe of countries and US states which have challenged the underpinnings of the UN treaties. The Netherlands initiated this challenge with the de facto decriminalisation of cannabis, and the spread of cannabis café culture during the 70s and 80s. In 2001 Portugal changed its laws in order to focus resources on health-based measures by decriminalising possession of controlled drugs. Switzerland has for several decades been a pioneer of harm reduction among injecting drug users, Czechnia has decriminalised personal possession and home cultivation of cannabis up to 10 grams, Lichtenstein is proposing regulating cannabis, and several eastern European countries have personal possession and medical use of cannabis decriminalised. South American countries such as Uruguay have legalised the coca leaf and cannabis, Mexico's Supreme Court has declared the illegality of cannabis to be unconstitutional, and many other South American countries have decriminalised personal and/or medical use of cannabis. Canada legalised the commercial sale of cannabis in 2018, the US has seen 33 states decriminalise the sale and production of cannabis for medical use, and the legalisation of cannabis for recreational use in 11 of the states. This prompted the US State Department to issue a press release in 2014 declaring:

> *"Things have changed since 1961. We must have enough flexibility to allow us to incorporate those changes into our policies … to tolerate different national drug policies, to accept the fact that some countries will have very strict drug approaches; other countries will legalize entire categories of drugs*" (William Brownfield, Assistant Secretary of State, Bureau of International Narcotics and Law Enforcement Affairs, Reuters, 2014).

This challenge to the dominance of the UN treaty obligations has prompted worldwide debate on the future of global drug policy.

Political and Policy Background: Who Makes the Policy?

Formation and implementation of drugs policy in the UK is three tiered; international, national and devolved.

International

As mentioned, the international drug control regime is governed by the 3 UN Conventions on narcotic and psychotropic substances, which regulate manufacturing, trade, possession and restrictions to illicit drugs. The most important convention is the 1961 protocol, amended by the 1972 protocol, which states first and foremost that the aim of the Convention is to maintain the health and wellbeing of humanity by restricting and eliminating access to controlled substances, unless for medical purposes, and to recognise the role society has in preventing drug abuse. This, they felt, was best done through criminal measures aimed at drug producers, traders and users, in combination with social measures to address underlying issues. The United Nations Office on Drugs and Crime (UNODC), oversees the implementation of these conventions, however the main debating body which is responsible for reviewing and overseeing the scheduling of prohibited drugs is the Commission on Narcotic Drugs (CND). The CND receives recommendations from the Expert Committee on Drug Dependence (ECDD), a department of the World Health Organisation (WHO) who are responsible for evaluating the medical and abuse potential of all psychoactive substances. While the UN consists of 193 member states only 53 of these countries have representation on the CND meaning that many member states do not get an opportunity to contribute to international debates on drug policy and control. Furthermore 90% of the UNODC's funding consists of voluntary contributions from member states, making it "*particularly responsive to those member states that finance it* (UNU report, 2015). While the CND is the primary debating forum within UNODC, the International Narcotics Control Board (INCB) is the final body responsible for interpreting the Conventions. Made up of 13 independent experts, this Board has responsibility for monitoring and ensuring compliance with the Conventions, as well as providing nominal support to help states implement their treaty obligations.

Although the international drug control structures have been in place for over 50 years, it was not until 1990 that member states met to reaffirm a commitment to the conventions and agreed to issue a 'Political Declaration and Programme of Action' (UN, 1990). This was in response to the growing number of illicit drug users and an increase in drug related crime and harm resulting from the manufacturing, importation and selling of drugs, in particular the spread of blood borne viruses such as HIV (Human Immunodeficiency Virus) (ibid: 5). Although the declaration recognised the links between health and drug use, why illicit drug use was on the increase (such as the loss of communities resulting from deindustrialisation in many Western countries, or the levels of poverty) was not addressed. The declaration agreed to strengthen the controls on the use and trafficking of narcotic drugs and resolved to "*protect mankind from the scourge of drug abuse and the illicit trafficking in narcotic and psychotropic substances* (ibid: 6).

The next meeting in 1998 was the 'General Assembly' at its twentieth special session on the world drug 'problem'. Member states agreed to adopt a Political Declaration and Plan of Action laying out a commitment once again to the Conventions, but importantly this time they agreed to

report biennially to the commission and meet again in 2009 to assess the Plan of Action. Crucially the tone of the Declaration recognised the importance of harm reduction and the role community plays in reducing drug related harm (UN, 1998).

In the 2009 Declaration an interesting twist developed. In the opening statement of the Declaration the United Nations Under-Secretary-General and Executive Director of the United Nations Office on Drugs and Crime, Mr. Antonio Maria Costa spoke of the need to find a balance between the criminalisation of drug users and the legalisation of drugs (UN, 2009:3). This was only one aspect of note however, and overall drug policy reformists were disappointed (IDPC, 2009). The thrust of the Declaration focused on supply and demand reduction through criminal sanctions while at the same time increasing the provisions of harm reduction, support and prevention for people dependent on drugs. In contrast to the previous Declarations this one focused in-depth on what nation states and the international community should focus their attention on. It was planned that the next meeting would be a Special Assembly in 2019 in which all the targets and agreements set out in 2009 could be assessed and reaffirmed. However, in response to growing frustrations and increasing 'flexibility' in the reading of the treaty obligations by various member states, Mexico, Columbia and Guatemala successfully campaigned for the 2019 session to be brought forward to 2016. Furthermore, in order to widen participation beyond the limitations of CND they convinced member states of the need to hold a General Assembly Special Session on Drugs, allowing for wider participation and increased deliberation than would otherwise have happened.

The importance of widening participation cannot be understated. For the first time in the history of international drug control policy the concept of civic engagement had been incorporated into the decision making process. While still limited to the democratic mechanism of representation (as opposed to other democratic engagement tools such as collaboration/participation of stakeholders) and the limits of governments to engage with their publics in international politics, there were significant contributions from non-governmental organisations ranging from the Global Commission on Drug Policy to the Swedish Youth Temperance Movement. Furthermore, the Civil Society Task Force, supported by the UN and set up by the Vienna NGO Committee on Drugs (VNGOC) and the New York NGO Committee on Drugs (NYNGOC), initially gauged the involvement on civil society in drugs policy around the world with a view to providing avenues of representation at the 2016 United Nations General Assembly (UNGASS) and beyond. The reason for this engagement was the growing acknowledgement that many countries and individuals wanted to see a change in the international treaties to allow a relaxation in drugs law, especially around cannabis.

The need for deliberative dialogue was highlighted in a report published by the UN University, who gathered stakeholder opinions throughout 2015 in the lead up to UNGASS 2016. One of their main recommendations stemming from their findings was that UNGASS 2016 must

be looked at as a springboard from which conversation and deliberation will flow from, up to and beyond the Political Declaration and Plan of Action in 2019:

> *"[t]he global drug policy conversation between UNGASS 2016 and the renewal of the UN Political Declaration and Plan of Action should not aim to create a one-size-fits-all policy discourse to replace the 'War on Drugs', but rather be based on national-level flexibility coupled with agreed global principles – or, as we put it earlier, principled pluralism"* (UNU, 2015:29).

States were encouraged to actively engage their publics in order to understand and highlight localised research and solutions to drug harm, regulation and control, in addition to creating a global conversation guided by three principles: 1) protection of human rights; 2) promotion of human development; and 3) guidance by the best available scientific evidence. This focus on deliberative process echoes the focus of the research. An important driver of the research was the desire to explore broader engagement methods using deliberative processes such as respectful dialogue, and creating safe spaces for deliberation, so that broader civic engagement could take place. Unfortunately UNGASS 2016 did not produce the policy reform many were looking for, including any meaningful deliberative engagement with wider public, and reiterated the commitment of the previous three conventions. The only ray of hope for reformists was the change in language to focus on drug *abuse* as opposed to eradicating all drug *use.*

In the international context the European Union has a limited impact on national drugs policy as all member states are UN signatories and therefore constrained by the UN Conventions. However, the EU has issued several 'Decisions' which strengthen the current UN Conventions, of note: the 2004 Framework Decision on penalties for trafficking, (Council for the European Union, 2004) which sets out minimum criteria for drug trafficking offences, and the 2005 Council Decision on new psychoactive substances (Council for the European Union, 2005).

National

UK drugs policy is governed by the Misuse of Drugs Act 1971 (MDA) which was enacted in order to fulfil the 3 UN treaty obligations mentioned above. In addition, there is: the Misuse of Drugs Regulations 2001 which set outs the schedule of each drug; the Medicines Act 1968, which regulates the manufacture and supply of medicines; the Drug Trafficking Act 1994, which makes it an offence to sell items associated with the preparation and use of controlled drugs; the Crime and Disorder Act 1998, which implements Drug Treatment and Testing Orders for those convicted of drug offences; the Drugs Act 2005, which among other things made fresh magic mushrooms a class A drug; and the Psychoactive Substances Act 2016, which criminalises the sale and import, but not possession, of new drugs designed to have a psychoactive effect.

Controlled drugs are placed in a classification system, with A being the most harmful, and C being the least harmful. Measurements of harm and recommendation to the government on classification is taken from the Advisory Council on the Misuse of Drugs (ACMD). However the ACMD's advisory role is becoming increasingly at odds with government decisions on the classification of psychoactive substances (Stevens, 2018). The main leaders in policy are the Home Office and the Department of Health, under the banner of Drug Misuse and Dependence. These departments produce policy reports on commentary, evaluation and implementation of UK policy.

This research is focused on narratives within Scottish drug policy formation, and participation of stakeholders within the policy making process. It will therefore focus specifically on the workings of the devolved Parliament, looking only at national or international policy when it intersects with devolved policy, for example with criminal sanctions.

Devolved: The Scottish Position

In 1998 the Scotland Act devolved many aspects of political and legislative competence to the newly formed Scottish Parliament. However, while Scotland has always retained a separate criminal justice system (Act of the Union 1707, article 57), the criminal laws contained within the MDA were not devolved. The MDA is therefore a reserved matter under Schedule 5 B1 of The Scotland Act 1998. There has not been any formal justification as to why the MDA was reserved; it can only be assumed, by tacit understanding of the debates surrounding devolution, that the reserving of these powers was in order to maintain uniformity in sentencing and classification throughout the UK, and to make sure Scotland could not deviate from UN treaty obligations. The only change to this reservation is from Section 19 of the Scotland Act 2012 which devolved power to grant licenses for the prescription of opiates and cocaine to the Scottish Ministers, and the recent changes in cannabis legislation to allow all Specialist Consultants to prescribe cannabis (prescription rules being a devolved matter).

Interpretation of the MDA, where possible, is devolved to the Scottish Parliament, and Scotland's current drug policy is set out in the document 'The Road to Recovery' (2008), and the 2018 refresh of this strategy 'Rights, Respect and Recovery'. These documents set out strategic actions designed to promote recovery and reduce the impact of drug use through improving the life chances of those most likely to develop 'problematic drug use'. In 2008 the Scottish Drugs Strategy Delivery Commission (DSDC) was set up to replace the Scottish Advisory Committee on Drug Misuse in order to help "*the Scottish Government deliver a drugs policy that is fit for the 21st century for all the people of Scotland*." (Scottish Government Press Release, 2009). The DSDC was dissolved in November 2014 and was replaced by the Partnership for Action in Drugs (PADS). This was disbanded in 2019 and replaced by the Drug Deaths Taskforce.

Because my exploration of participation in Scottish drug policy takes place from 2014-2018, and the focus is on the engagement I participated in, as opposed to the various policy governance shifts taking place, the following sections set out the shifting landscape in more detail.

Scottish Drug Policy Governance: Shifting Landscapes – 2012 to 2018

The term 'governance' is used to describe "*the processes and mechanisms by which policy is directed, controlled and held to account* (Hughes et al, 2010; UKDPC, 2012, 8). Furthermore, they recommended that: *"There is a need to develop and test the use of deliberative methods for engaging with the public around the complexities of the evidence base and the goals and options for drug policy*." (UKDPC, 2012, 4). This thesis focuses on participation within drug policy, as one aspect of good drug policy governance, and in particular I created and used a deliberative forum (The Scottish Drug Policy Conversations, discussed in chapter 3) to explore whether deliberative methods can increase meaningful engagement within participatory processes. The term 'participatory processes' encapsulates an array of participation tools being tried out in order to increase involvement in democratic decision making. The reason for this is that "*when policies are worked out* for *rather than* with *a politically excluded constituency, they are unlikely to engage all relevant concerns"* (Phillips, 1995-quoted in Smith 2009, 7: emphasis in the original).

Returning to Scotland, in 2012 there was media and political debate regarding drug related deaths stemming from the 2011 statistics which saw 584 such deaths. This prompted wider discussion on whether the current strategy of harm reduction as promoted by the 2008 Road to Recovery (including methadone treatment and needle exchanges) was in fact maintaining peoples drug use rather than stopping it (DSDC, 2013). In response to this pressure the DSDC were asked to conduct an inquiry into opioid replacement therapy provision in Scotland and their report in 2013 made twelve recommendations. One of the main findings that was picked up by the Scottish Government was the lack of "*effective information systems and relevant research into problems drug use and recovery*" (Scottish Government, 2015:2). The publication of this report arguably signalled the death knell for the DSDC: following the report the DSDC was disbanded and a steering group was set up to explore how these recommendations could be taken forward. In 2015 they published the 'National Framework for Problem Drug Use and Recovery'. What followed was complete overhaul of the Scottish drug policy advisory structure.

The first aspect was the creation of an Executive Committee to oversee policy formation entitled Partnership for Action on Drugs in Scotland (PADS). The aim of the committee was to "*provide the necessary leadership in order to continue to tackle problem alcohol and drug use in Scotland*" (PADS, 2016). The Executive Committee was chaired by the Minister for Public Health and Sport, and had several permanent members and several ad hoc members. Underneath this there were four (sometimes 5) further committees which looked at specific areas:

1. Reducing Harm and Drug-Related Deaths
2. Improving the Quality of Services
3. Building Recovery Centred Communities and Reducing Stigma
4. Lived Experience – to provide an executive advisory link between the policy formation and drug users/ex-users
5. Education - met irregularly

Alongside this, the government drug policy department was moved from the Justice Department to the Health Department and its name changed from the Drug Policy Unit to the Substance Misuse Unit (SMU). This change signalled a re-focusing of policy from (illicit) drug use to broader substance use including alcohol, and focused attention on the *mis*-use of substances as a health issue, as opposed to general drug use as a criminal issue. In doing so it effectively ignored the criminal sanctions imposed upon drug consumers in order to focus on the perceived 'problematic' drug consumers, predominantly injecting heroin users. This shall be explored in more detail in the chapter 4. A second outcome of this document was the commitment to broaden the advisory landscape:

> *"With a focus on a collaborative way of working between Government, sponsored organisations, academics, ADPs and drug services, the priorities identified within this document will inform the new groups making up the advisory landscape, articulate a clear direction of travel for those working in the drugs field and directly influence Government policy"* (Scottish Government, 2015: 10).

In order to articulate this commitment, the SMU were encouraged to engage with stakeholder groups. Representatives from the SMU attended our conversations and I was in regular contact with civil servants about engagement activities. In addition to this, the Scottish Government committed £80,000 for 3 years to establish a research network, the Drugs Research Network for Scotland (DRNS), with the aim of creating networks between the different stakeholder communities and identifying gaps in research and funding.

In August 2017, the Scottish Government released the drug related death (DRD) statistics for 2016 (NRS, 2017) to much anticipation. Close attention had been paid to England, Wales and Northern Ireland's release several weeks previously, with significant increases across the board. At the same time the UK Government released their updated drug strategy (Home Office, 2017) which, it was argued, "*promises enhanced monitoring of the prevalence of substances controlled by the Misuse of Drugs Act 1971, but offers no real prospect of reducing the harms associated with their use"* (Winstock et al, 2017, 1). In light of the publicity surrounding the English and Welsh DRD statistics the Scottish Government were prepped. Many people working within the drug policy arena, such as those who were part of my sample group, and colleagues on the Drug Harm Committee that I sat on, were hopeful that the media furore surrounding the numbers would

provide the window of opportunity needed to create advised policy reform. There had been some promising moves over the past couple of years, particularly in regards to stakeholder engagement and implementation of effective yet controversial initiatives (discussed in chapter 7). Despite this, there was frustration by many at the pace of change and the large cuts to drug treatment services that had also taken place over the last two years (Hamilton & Stevens, 2017). So it was with this in mind that the Scottish Government pre-empted the DRDs release, and consequences, by announcing a refresh of their drug policy strategy document 'The Road to Recovery 2008', at a conference hosted by the Scottish Drug Forum entitled 'Drug Policy through a Health Lens' (SDF, 2017a).

Drug policy communities in Scotland welcomed this announcement (SDF, 2017a; SDPC notes), and critical responses to the DRD statistics - which saw an increase of 23%, from 706 in 2015 to 868 in 2016 (NRS, 2016) - were tempered by the possibility of innovative policy shifts resulting from the proposed refresh. Despite this there was commentary from key policy actors including executive committee members of the PADS group (McCauley, Robertson & Parkes, 2017) and participants of the SDPC (SDPC, 2017a), reflecting the frustration, and in many instances cynicism, by policy stakeholders at the timing of the refresh and the fear that it may be more rhetoric than reality. As one interviewee noted:

> *"[t}hey are doing [this] because they have to, it's the drugs deaths which have risen to such a great height that they've been pushed to do it, they've been brought squealing to actually address it because the reality is what they have tried, and put their faith in in the past has not been working"* (Senior Drug Advisor).

Yet another comment came from members of the Scottish Government's Advisory Committee PADS, who, in a joint article wrote:

> *"The prevention of DRDs in Scotland requires an immediate and radical harm reduction led response, developed in collaboration with people who use drugs. Evidence-based solutions are available, but it is absolutely crucial that they receive support from all sections of Scottish society in order to destigmatise drug use and encourage people to seek help. The tragedy of Scotland's spiralling deaths from drug use is everyone's problem. The time for brave leadership and concerted action is now"* (McCaulay, Robertson and Parkes, 2017).

In the new structure it was interesting to note the lack of a committee dealing with the enforcement/justice aspect to health, despite the ability of Police Scotland and the Crown Office to set policy that directly impacts drug users. For example, at the same time as the Scottish Government were implementing the new policy framework, Police Scotland were in the process of changing their cannabis policy. Previously cannabis possession was reported as a crime and

those caught were processed through the Crown Prosecution Service (CPS). However, the majority of cases were either discharged or 'no further action was taken' (SDPC, 2016). According to the police representatives who attended the SDPC session on this cannabis policy (SDPC, 2016), a decision between the Lord Advocate, the CPS and Police Scotland was made to stop prosecutions of small amounts of cannabis (the initial proposal was all class B and C drugs) and instead issue Recorded Police Warnings. Interestingly the SMU were not consulted on this policy shift, at least not formally. This highlights an important finding that will be discussed further in the thesis- that policy decisions are often made without formal or meaningful consultations with stakeholders, and there appears to be no direct link between criminal justice responses and health responses to drug issues.

There is however, an indirect link via the focus on reducing health inequalities. In 2017 the Scottish Government set up a Health and Justice Collaboration Board (Scottish Government, 2017), that seeks to link health and community justice responses. While the overarching focus is on the need to reduce inequality in order to improve the wellbeing and life chances of individuals (NHS Health Scotland, 2017a, 2017b; Scottish Government, 2017a) there is specific focus on the impact of drug and alcohol use as risk factors in offending (NHS Health Scotland, 2017b, p.25). A stated vision of the Board is: "*We will work with others to improve health and wellbeing in justice settings, focusing on mental health and substance use"* (Scottish Government, 2017a, 3). The response is to increase collaboration between the different institutions responsible for wellbeing such as local authorities and service providers: "[*to] ensure the development of integrated care pathways for people within justice services and information sharing to ensure they receive continuity of alcohol support and treatment in both custody and the community"* (NHS Health Scotland, 2017a, p.26).

The important point here is that despite there being collaboration between justice and health, the focus is on health intervention *within* the custodial setting, as opposed to solutions that remove drug use from the justice setting. The implications of this are far reaching when one considers the aim of drug policy (contested), and highlights a growing tension within drug policy between public health responses and criminal justice responses. Furthermore, this focus on health highlights the issue that this thesis explores: the silencing of those drug consumers that do not fit within the 'problem' definition paradigm – recovery of 'problematic drug users'. As you will see, this speaks to a core finding in the research: that by shifting focus away from criminal justice interventions, yet still relying on them to support policy interventions, a section of the drug using population fails to be represented in the national strategy.

Throughout 2017 and 2018 there were initiatives to broaden engagement, and how this manifested from a participant's point of view is explored in this thesis. In 2018 the Scottish Government published an updated drug strategy called Rights, Respect and Recovery (2018), which signalled a further move towards a public health approach to drugs. However, in 2019, in

response to yet another increase in drug related deaths (27% increase in 1 year, from 934 deaths in 2017 to 1187 deaths in 2018), the advisory structure was unofficially disbanded and a new 'Drugs Deaths Taskforce' (Scottish Government, 2019) was set up. I say unofficially because there was no official disbanding of the committee, and no official announcement. Yet those of us involved in the committee (I was the user representative for the harms group) were not invited to any more meetings, and the chairs were instructed that there would be no more meetings. Indeed, one of my interview participants, who was also the chair of the harms committee and had been a government advisor for over 40 years, was completely removed from the government advisory structure. While I do not comment in depth on developments beyond the data collection period of 2015-18, it sets the scene and shows how the governance of drug policy in Scotland has been constantly changing, and, arguably, lacks structure or leadership, something which became evident as I engaged with the different policy groups.

On the other hand, the different changes to the governance structure is indicative of a government grappling with the re-focussing of drugs policy from justice to health. This move is in line with calls to establish evidence based drug policy, with most evidence pointing towards more public health engagement and community based solutions as opposed to criminal justice sanctions (UKDPC, 2012; Scottish Government, 2018).

Issues with the Formation of Drug Policy Evidence and the use of 'Experts'

In the last 20 years there has been a move towards 'evidence based policy' that seeks to utilise research evidence in the development of policy (Bennett & Holloway 2010). Evidence based policy often fits well with morally driven policy, such as drug policy, as it utilises rational 'scientific' approaches to the analysis of evidence in order to justify policy decisions (Stevens, 2011; Ritter, 2015). It attempts to bridge the gap between knowledge production and policy making however, there is little research into the effectiveness it has in bridging this gap (Smith, 2013, ch.3; Lancaster, 2014; Ritter, 2015; Moore et al, 2011). There is also criticism that evidence based policy fails to react to the changing pace of the policy process; evidence of effectiveness may be slow to be translated into policy practice, by which time new evidence has emerged (Lancaster & Ritter, 2013; Ritter, 2015). In response to this criticism, policy makers have taken to using the term 'evidence informed policy' (Head, 2008). This term reflects the fact that policy is made of multiple inputs, one of them being systemically reviewed evidence, and the understanding that '*[a]s in other policy spheres, drugs policy is shaped by a number of competing influences including politics, ideologies, values, the media, perceived public opinion and pragmatic constraints such as funding'* (Duke and Thom, 2014, 970). It is therefore not possible to have a policy based entirely on research evidence, however, what political, ideological and value based ideas are incorporated into the development of policy are a matter of debate (Stevens, 2009; Head, 2008; Duke and Thom, 2014, Smith, 2013).

While there has generally been an increase in the use of evidence in drug policy making, or at the very least a commitment (c.f. Scottish Government, 2018), there has been less attention paid to the role of the researchers in producing such evidence. Given that researchers play such an important role in the dissemination of knowledge within drug policy it is imperative that the "assumptions and worldview" of the researchers are looked at (Ritter, 2015, 183). The way in which a 'problem' is identified and understood will influence the way it is researched, and which options and solutions will be suggested. The definition of the 'problem' defines the scope of the solutions. The research design itself can define the 'problem' by selecting the questions, the outcome measurements and the data analysis techniques, which then creates a 'body of knowledge'. This knowledge is then assumed to exist outwith the research process yet is in fact a result of the techniques used, and the paradigm from which the researcher is working: the policy solutions will match the problem definition (Ritter, 2015). I shall be exploring this in more depth in chapters 8 and 9, but for now the following chapter will further develop the discussion on the role of the researcher in developing evidence, and how ones world view impacts the way in which the research is framed, right from the start.

Chapter 2

Setting the Scene: Narrative and Meaning in Policy

Background Knowledge and the 'Situated Knower'

As discussed in the previous chapter, there is a complex relationship between the concept of knowledge, and the concept of evidence. It is for this reason that explorations of how we as individuals develop knowledge, and how life experience impacts this knowledge, is important. Traditional Cartesian models of scientific inquiry follow the belief that knowledge exists outwith the knower - the *atomistic* model of knowing. However, phenomenological and non-positivist approaches tend to incorporate some understanding that knowledge cannot be separated from the knower. For example, feminist epistemological approaches have developed the concept of *situated knowers* (Haraway, 1988) - that there are some experiences which cannot be known by others, because the structure of society and the systemic differences between genders results in experiences that cannot be accessed by the other gender. This concept can be expanded to social position and other systemic differences in society (Fricker, 2015). Feminists, in general, argue that these categories (in particular gender) are relevant as long as society is structured along the lines that differentiate between gender and social class (Grasswick, 2018; Harding; 1991). Broadly speaking the acknowledgment of where the knower is in space and time will impact the research development and findings (Hartsock, 1983; Harding, 1986; Grasswick, 2018).

This concept of situated knowing links strongly with the concept of 'background understanding' that is important in both philosophical discussions on understanding (Hegel, in Houlgate 2013; Gadamer, 2003; Wagenaar, 2015, ch.7) and interpretive research (Yanow, 2000; Schwartz-Shea and Yanow, 2012, ch.2; Wagenaar, 2015, ch.7). Ordinary understanding involves much more than just seeing, or knowing. It is a sensory experience that involves "*intentions, feelings, expectations, perceptions, memories and embodiments*" (Wagenaar, 2015, 197). It is a process that is often involuntary, participative and interactive – when we are confronted with a situation that requires an understanding there are processes at work that rely on background knowledge which is virtually unknowable to us – even with constant self-reflection. Philosophical hermeneutics (the basis on which interpretive research is built) however comes from the standpoint that: *"understanding is not a separate activity, to be switched off when we need it; it is life itself, simultaneously emerging from life and always answerable to its challenges and demands"* (Wagenaar, 2015, 199).

The setting [context] is important as it is the background to our actions and understanding. When we act we cannot grasp the full implications of our actions, the hidden meanings that may be portrayed, or the consequences of our actions. Background understanding is described by Gadamer as "*Zuwachs un Zein*" or a 'surfeit of being': that vast repository of experience, memory,

cultural impressions, norms, and desires, ultimately can be described as the unconscious mind (Taylor, 2002; Wagenaar, 2015; Grondin, 2003). Background understanding is *activated* when we interact through our practices (actions), making us engaged agents capable of interpreting our environment and interactions. This form of understanding comes to the fore when we work on it, improve it to fit the situation, and then retreats to the background again.

Situated knowledge has come under criticism however, in particular from Carol Bacchi, whose 'problem' analysis approach I use throughout the thesis (Bacchi, 2009). Bacchi highlights the difference between *situated knowledge* as set out by Haraway and others, and *subjugated knowledge,* as set out by Foucault. The issue Bacchi sees is that situated knowledge makes the claim to be representing a 'better' form of knowledge, by putting the experience of the 'knower' at the fore. However, this presents us with a problem. If all knowledge is situated (the claim that knowledge is a result of the socially situated position of the individual), how is it possible to have a "preferred" knowledge. It presents us with a recursive issue: if everyone's knowledge is situated, how is it possible to ever know 'the truth'.

A way of addressing this is to make it clear that there is no claim to a final truth: knowledge is intersubjective - truth is a temporary agreement in an ongoing conversation – and the exploration of a topic is about developing understanding and meaning around that topic. This Habermasian notion of truth as subjective is a key underpinning of the thesis, hence the use of narratives. It also speaks to Foucault's *subjugated knowledge.* This form of knowledge is not about the content (truth) but the way in which knowledge becomes the common sense taken for granted kind of knowledge, and how certain groups are discredited from being able to participate in that knowledge development. Foucault's knowledge is therefore about the relations of power, rather than the pursuit of the truth.

> *"Subjugated knowledge's", in Foucault, include forms of "erudite" knowledges and "disqualified" knowledges. "Erudite" knowledge's consist of "blocks of historical knowledges that were present in the functional and systematic ensembles, but which were masked". The role of critique is "to reveal their existence by using, obviously enough, the tools of scholarship… The analytic task is to bring all these knowledges to the fore, to contribute to an "insurrection of knowledge's" in order to challenge "the centralising powers linked to the institution and functioning of an organised scientific discourse" (Foucault 1980: 84). To "emancipate" "subjugated knowledges" from "subjection" renders them "capable of opposition and of struggle" and of being used "tactically"* (Bacchi, 2018).

This concept of knowledge was extremely important for my research. I initially grappled with the idea of knowledge as a concept, having had so many different experiences that did not conform to mainstream narratives. As discussed, I did not enter the drugs policy arena with a blank

slate. I held deeply ingrained ideas about what drug policy should look like, the kinds of stakeholders involved, and way in which we should be involved. Furthermore I came to this research as an active drug user, with decades of drug using experience. My involvement in so called deviant groups (ravers, clubbers, drug using communities) has meant that my knowledge of these communities differs significantly from those who do not have this experience, and arguably falls within the remit of subjugated knowledge. This meant that my understanding of what 'problem drug use' and other terms such as 'drug harm' present in the policy world, held meaning for me, and this meaning was attached to stories and experiences I had developed over the years. Often my meanings conflicted with official meanings, resulting in competing ideas of how a term should be used, and ultimately what the 'truth' was. My knowledge of the drugs themselves, and the issues surrounding drug using communities, was from both a 'user' perspective and a 'professional' perspective, yet did not fit in with the narratives being put forward by institutions. For example, in drug policy the term 'drug user' was used to describe a section of the drug using population who use 'problematically'. I challenged this term constantly because I, and others, felt that it hid the real meaning behind it, and masked the fact that the majority of drug users are not 'problem' users. Indeed the term 'problem drug user' is one that shall be explored and critiqued throughout this thesis. The reason I use subjugated knowledge is to alter the accepted understanding of how evidence is produced and valued in drug policy. In doing so I aim to produce counter and meta narratives as a solution to what is both an empirical and epistemological challenge.

Narrative Habitus

A recent development in narrative is the concept of narrative habitus, first proposed by Frank (2010) as a way of describing an '*inner library of stories*' (52-53) that one intuitively reaches for when trying to make sense of the world. Fleetwood however develops this idea to make it more relevant to criminological analysis. In her 2016 article she makes the compelling case for linking Bourdieu's concept of habitus with narrative.

The overall gist of the argument shows that Bourdieu's development of agency is complimentary to narrative. It has been critiqued that Bourdieu's work focuses too heavily on the 'field' (the external social world we all share and live in) and habitus (the collection of life events/culture/perceptions etc that shape an individual and how they relate to the world), and pays less attention to individual agency (the creative, spontaneous element). However, Fleetwood argues that this is not the case, and that his theoretical writings show there is a flexibility within his concepts that take into account the dynamic between agency, habitus and field. He connects "*objective structures with their subjective representations*" (Fleetwood, 2016, 181).

Bourdieu was predominantly concerned with how language is used as a form of class domination. However, he does not focus on what people say (the content of the language) and

Fleetwood develops the concept of narrative habitus by using Bourdieu's theory of social practice to support this theoretical development:

> *"The notion of a narrative habitus can be summed up as follows. In the same way that Bourdieu understands the habitus as the internalisation of one's position in the field, the narrative habitus is the internalisation of the narrative doxa (common sense) pertaining to the field, including vocabulary, narrative formats, tropes, discursive formats and subject positions etc. Creativity is possible within the limits prescribed by the habitus. The narrative habitus structures individuals' narratives and narrative identity. It sustains and motivates action in two ways: narratives may be habitual, as ongoing rationalisations for behaviours, or evaluations may take place through narrative. Finally, narrative doxa (common sense – or master narratives) pertaining to fields structure how stories are received, including notions of truth"* (Fleetwood, 2016, 181).

Habitus here is the internalisation of one's experience in life, and similarly the *doxa* of that position is internalised. People are predisposed to certain narratives because of the *doxa* surrounding that field. The *doxa* is developed because of habitus: people are preconditioned to view certain stories/narratives as 'common sense' resulting from knowledge developed from their life experience. Narrative habitus therefore is the collection of narratives that guide an individual's perception and action, the stories they tell themselves and are told that help them make sense of their environment. Bourdieu was more focussed on ways of knowing that did not involve discourse – "*schemes are able to pass directly from practice to practice without moving through discourse"* (Bourdieu, 1990, 74). However, Fleetwood convincingly argues that it is a small jump from habitus (our understanding of the field based on practice) to narrative habitus (understanding of the field based on discursive communication).

Narrative habitus is therefore the recognition that narrative allows the individual to create their own reality through discourse, but that this discourse is constrained by the habitus –the environment one finds oneself in. Narratives interact with habitus by helping one make sense of experience – habitus is the vast background knowledge we have from our internalised structure, narrative is that which guides what new experiences (and narratives) we engage with. In this way narrative habitus links closely with the concept of the situated knower and background knowledge discussed above, and provides a framework by which situated knowledge can become shared structural realities. The way that multiple perspectives are often presented is through dialogue between actors: *"Only by presenting 'multiple perspectives that correspond to the multiplicity of co-existing and sometimes directly competing, points of view', can we see the full picture"* (Fleetwood, 2016, 180).

Positionality: To talk about me or to not talk about me, that is the question

Taking the concept of situated knowledge further, a way of incorporating this into research is through the use of positionality and auto-ethnography. Auto-ethnography has been described as "*an autobiographical genre of writing and research that displays multiple layers of consciousness, connecting the personal to the cultural*" (Ellis & Bochner, 2000, 739). However, for me the question was, why include anything more than a snippet here and there, or a bit of a chapter on my thoughts about the process etc? Why document the journey I have taken as I worked through the process of learning, personally and professionally?

The answer is that stories have audiences, and they guide the stories too. Genres are written with an audience in mind; stories aimed at children, crime thrillers for those who enjoy suspense, reports are written for people who need the information, and policy briefs are written so that they can be easily fed into a policy process. This is a thesis, and as such my audience is you. I believe that my journey of discovery is of sufficient interest in that it plays a major role in how I conducted my research, and the understandings I came to. Furthermore, while there is an increasing interest into why participatory processes should be part of drug policy formation, there is little research into how it is actually carried out. By peppering the research with my own stories relevant to the topic, you will see how my thinking evolved, what ideas resonated with my own experience, and how these influenced the decisions I took in coming to conclusions. Furthermore, my experience in the drugs community, both as a drug consumer, drug worker and policy advisor means that I bring to this study a personal and professional understanding of the narratives present in each community, and the challenges in creating pathways for stakeholder participation.

Another important reason for using aspects of auto-ethnography in this thesis is my desire to develop empathy and compassion by creating common stories that we can all relate to and understand. As Frank (1996, 158) writes, "*storying the "I" is about "thinking with stories" by joining with these stories and allowing one's own thoughts to adopt the story's inherent logic of caution, its temporality and its narrative tensions*". Furthermore, as we shall see, a major aspect of the research was the exploration of the silences in drug policy, and these silences are around drug use for pleasure and intoxication. As mentioned I have spent many years involved in drug using communities, and the use of auto-ethnography helps to shine a light on this ignored and silenced community.

Yet this approach also presented challenges in regards to my own positionality within the research, for as Ettorre highlights: "*[w]e transform our personal stories into political realities by revealing power inequalities inherent in human relationships as well as the complex cultures of emotions embedded in these unequal relationships."* (2017, 357). My role as researcher, drug user participant *and* policy advisor, meant that I was at times part of this power imbalance. By being able to access and influence people and institutions not readily available to so called 'lay' people,

I was part of the institutional structure, while at other times I was at the part of the stakeholders who were at the sharp end of these unequal relationships. This exposed me to potential harms, for as Blakeman (2007) points out:

> *"[t]he double-edged side of reflexivity* (disclosure through positionality) *is that, through disclosure, researchers are open to challenge about research ethics, but unless the hidden ethnography is made more transparent a more realistic account of fieldwork will not be forthcoming"* (701).

I explore this in the conclusion, however I mention it here because as a result of these reflections I sought to use my knowledge of the language of power to redress the unequal relationship inherent in institutional processes such as policy development, and I develop this throughout the thesis. This ties in with the concept of subjugated knowledge as discussed above. By using my position within the subjugated community, I was able to highlight and "*emancipate the subjugated knowledges*" (Foucault 1980: 84) by giving them a voice: through the participation group I set up (set out in the next chapter); by bringing them to the policy groups I was involved in; and in this thesis.

Using Dialogical Meaning to Create Meaningful Dialogue

Dialogue became an important tool in my research, and here I explain what I mean by dialogue, and how it can be a powerful tool in creating conditions of trust and meaning. Dialogical meaning is a focus of interpretive research, with a starting point that meaning is a result of our everyday experiences, some of which fall outwith our capacity to fully understand (Wagenaar, 2015, ch.8). Meaning emerges through dialogue between actors and the world. In discursive and hermeneutic analysis, meaning is seen as an object of research (Fay, 1996, 146; Wagenaar, 2015, ch.8), with the researcher setting out to 'uncover' what the meaning is to the actors in the research. In contrast, because meaning emerges through dialogue between the researcher and actors/objects of research, there is no 'uncovering' of meaning, but rather the emergence of meaning that can only be articulated by the interpreter, and is dependent on the life experience of that interpreter (Wagenaar, 2015, ch.8). Furthermore this meaning takes place in 'emergent time': *[U]nderstanding arises from a situation of engagement, that it is shaped by a particular perspective that we cannot transcend, and that it takes the form of a "conversation' with the object of meaning".* (Wagenaar, 2015, 196). Dialogical meaning therefore does not attempt to 'uncover' the truth in the way hermeneutic and discursive meaning, or any form of scientific research, attempts to do. Instead it looks at broadening understandings, and individual horizons through conversations with the object (person, document etc): *"In the dialogical conception of meaning, on the other hand, meaning emerges only in relation to the interpreter. As a consequence meanings change when an object of action meets a new interpreter, or more likely, a community of interpreters"* (Wagenaar, 2015, 54-55).

In this way the use of dialogical meaning compliments the use of subjugated knowledge as outlined above, by not attempting to get to the truth, but to explore what 'truth' means to ourselves and others.

Dialogical Meaning and Expanding Horizons

Horizons is a term coined by Gadamer (1976) and is important in understanding dialogical meaning. Think of standing on a hill and looking towards the horizon. Then imagine that the hill suddenly gets half a mile taller, with you standing on it. Your horizon will have shifted and landscape that was once beyond that horizon will now be visible. We all operate within our own horizons, but the key here is that horizons can shift, expand and contract and intermingle with other horizons. Think of the hill and imagine several other hills with people on them. As they rise up to your level they are able to perceive what you perceive, and vice versa. As understanding takes place through dialogue, our horizons shift – we can feel this when we have those moments of insight, when you feel you mind expand as a result of information that changes the very foundation of your concept of reality. Here I reflect on one of my early experiences:

> *"My first memory of an expanding horizon comes from when I was about 5 years old. I cannot remember the exact context in which it expanded, on reflection it may have been to do with getting the bus. We used to get the bus to Tollcross in Edinburgh, about 2 miles from my home. The journey of the bus, for a 5 year old, followed a certain path, and in my mind that was the boundary of my reality, Tollcross. Other places existed within that boundary such as the playpark, my school, the local church, the roundabout. One day I had the realisation that the world was larger than this 2 mile radius, that it took in the whole of Edinburgh city, and beyond. The physical feeling of this understanding was so strong that I had an existential moment that has stayed with me to this day. My world, my horizon, expanded to include all those things that I could not see immediately, but were out there in the same way Tollcross was out there, and accessible in the same way Tollcross was accessible by bus."*

While this example may highlight the personal growth and developmental horizon expansion that my 5 year old self experienced, it sums up the experience of expanding consciousness that can accompany dialogical processes in other worlds such as policy. In less profound ways, dialogue creates these expanding horizons by encouraging understanding between actors. This deeper understanding can shift the boundary of the individual's reality, opening up aspects of themselves and the world around them that had previously been hidden from view. The concept of 'horizon' is used in this context by Gadamer, and Wagenaar, to show that "*we are always part of the situation we are trying to understand…we live and understand in emergent time" (*Wagenaar, 2015, 203). Meaning exists within us, as opposed to 'out there'. Our meanings are unique to us; my perspective will be different from yours because of my background

experience, but we can build bridges between perspectives (and therefore expand our horizons) by engaging in dialogue with other perspectives. The concept of horizons contradicts the idea of an autonomous, independent subjectivity, as well as a detached objective observer. It encompasses the idea that we are constantly being "*thrown into the world*" (Wagenaar, 2015, 205). By a fusion of horizons our understanding is constantly shifting and emerging, never static, particularly if you are acting as an engaged agent (taking on board all these concepts and reflecting on you own process using dialogue): *"Understanding therefore, is better described as 'coming-to-an-understanding': ongoing, provisional, fallible, always open to revision"* (Wagenaar, 2015, 206).

Because dialogical meaning involves cultivating a mindset that is comfortable, or least aware, that one will never have full control over our objects of study, or have full access to the reality we are taking part in, there needs to be some ethical considerations. Firstly, this process involves self-reflection, and this is not always easy. In order to comprehend the above we need to accept that we are not fully transparent to ourselves, or willing to open up to others. This requires an element of vulnerability and trust. In order to create a fusion of horizons, particularly in dialogue between people, you need to be willing to change your assumptions, have them challenged. Not everyone is able to do this, and I found this particularly hard to begin with.

Secondly, coming to an understanding requires that the parties involved are willing to "*function together*" (Taylor, 2002, 128). In order to do that there needs to be mutual respect and openness. Having mutual respect and openness requires one to feel that the other has something to teach them, that they can learn from their perspective. Part of my research methods involved interviews, and an example of this 'functioning together' can be seen when I started to analyse my interview transcript data. On the one hand I felt required to interpret the interview data and create new understanding based on it, on the other hand I was strongly committed to the concept of respectful dialogue, and avoiding interpretation based on my own prejudices and beliefs. I overcame this dilemma slowly by understanding that the researcher can add without imposing, and by incorporating stories into my findings that allowed me to present chunks of data that retained the perspective of my interviewees. By incorporating dialogical meaning into my analysis I overcame the desire to 'uncover' a truth, instead focussing on how I perceived the interaction, and the meaning that emerged from it. At the risk of over-quoting Wagenaar, it is this quote that underpins my approach perfectly:

> *"Dialogical meaning is, thus, a human condition, an awareness of the open-ended, fallible, and shared nature of our understanding of the world, and of our tentative, never finished attempts at elucidating and overcoming the indissoluble partiality of our position in the world. In dialogical meaning understanding is intimately tied to action. It emerges from the patterned activities we engage in when we grapple with concrete situations that present themselves to us as in need of being resolved. Meaning emerges from our interaction with others and with the world"* (Wagenaar, 2015, 57).

Meaning, therefore, is created throughout the research process and understanding emerges from immersing yourself in the process. Importantly dialogical meaning is developed through dialogue between actors. A way of creating dialogue is through stories, and these stories can help us understand larger narratives that provide the master, and counter meanings to individuals and groups within society. By cultivating a dialogical approach to meaning, meaningful dialogue is possible.

Exploring the Role of Narrative in Research

Social science is concerned with meaning making, and recent developments have seen narrative analysis as an important way of understanding meanings (Fischer, 2003). Narrative study stems from anthropology and the study of narratives in religious texts such as the Bible and the Talmud (Czarniawska, 2004; Douglas, 2007) and moved to folklore and mythology with the publication of Vladimir Propps' Morphology of the Folktale in 1928. This instigated a swathe of contemporary research in the linguistic and literary disciplines where the structure and content of stories were subjected to much analysis and discussion (Czarniawska, 2005; Wagenaar, 2012; see further Roland Barthes and Mikhail Bakhtim). The use of narrative research and analysis began to spread out from the earlier disciplines around the 1960s with the publication of Labov and Waletszky's essay 'Narrative Analysis: oral versions of personal experience' (1967), and historian Hayden Whites' book on the historical imagination (1973). Narrative research in the broader social sciences took off in the early 1980s in response to a number of factors including: the increase of women in these areas (Griffiths and McLeod, 2008) andthe recognition that narrative plays a key role in the way we communicate (Orr, 1996), make sense of organisational life (Weik, 1995) and organize political life (Schram & Neisser, 1997; Roe, 1994).

Narratives are a way to communicate with each other using stories, giving us an understanding of not just individual lives but the cultural narrative or community narrative (Bruner, 1991; Gee 1986; Mischler 1985; Reissman 1993): "*The power of narrative is not so much that it is about life but that it interacts in life*." (Daiute, 2014, 2). Having said that, there is no single definition of what constitutes a narrative or story in social science, however, there are foundations and convergences that most narrative analysts, or those writing about it, appear to agree on (laid out below).

Generally speaking narrative and stories are used interchangeably within social research, however I found this approach messy, and at times confusing, so took inspiration from Feldman et al (2004) and Wagenaar (2012) and chose to distinguish (as much as possible) narratives from stories. In this research narrative is the overarching themes that emerge from the stories, and will be presented as the master narratives and counter narratives. Stories are individual 'subsets' of the narrative which make up the broader theme (Feldman et al 2004). Multiple stories therefore create

the overarching narratives, allowing for numerous, and at times competing stories to be incorporated (Czarniawska, 2014). Yet, while a distinction helps to clarify, there are often times when the two definitions overlap.

The classical structure of a story is Aristotelian: a beginning, middle and end, with a plot that involves the "reversal of the hero's fate" (Wagenaar, 2012, 201). It has also been argued that a story must have a sequence of events (Labov and Waletzky, 1967), while others argue that it is the consequences of stories that make them relevant (Young, 1987; Czarniawska, 2004) or functions (Wagenaar, 2000; Forester, 1999). A further twist to the tale, and one that takes Aristotelian development further, is the mythologist Joseph Campbell's elaboration of 'the hero's journey' in his book '*The hero with the thousand faces*' (2008). In this development the story not only has a beginning, middle and end, with a plot, a sequence of events and a function, but it also sees the hero overcoming adversity in three distinct phases, ending with a reversal of the hero's fate by moving him onto the next level of consciousness (marriage, wealth, happiness etc.).

The template provided by sociolinguist William Labov tweaks the Aristotelian structure. In this the story starts with an abstract (introduction) that sets the genre and the style. It then orientates the reader by setting out the time, place and key characters. The story then develops a complicating action which requires the characters to react, and this is then resolved and evaluated by exploring what happened, was it done well, etc. Finally a coda ends the story and, if the story takes place within a conversational setting, this is the signal for other speakers to come in. Labov felt that this template needed to exist in order for narratives to be considered 'fully formed' (Frank, 2015, p.10).

According to Charles Tilly (2006) stories differ from 'technical accounts' in that they rely on imagination and are character driven. Stories can be wide ranging, all forms of communication can be in story form, as long as they follow a sequential order and have some elements of connection. Time is therefore another important component of the structure of a story, yet it is not necessarily linear but temporal, and often cyclical, as explored below (Bhaktin, 2002; Ricoeur, 2002). A story therefore consists of elements such as plot, characters, beginning/middle and ending which signal to the reader they are engaging in a story. The bedtime test as Frank (2015) describes it is helpful: if your child asks for a story they will not be happy with some complex rendering of an action, they need a beginning, a middle which usually involves some kind of suspense or challenge that needs to be overcome, and a ending, or resolution (Frank, 2015). Stories therefore speak to the child in us, the point in time when logic, reason and structure were only beginning to be formed.

Stories are ultimately subjective because they are about the individual experience, but often they reach out to a larger audiences by tapping into universal themes that touch every reader. "*Storytelling, as a distinct epistemic mode, accords with knowing as coming -to-an-*

understanding…[they] are meant to be provisional and temporary. And also interactive and dialogical." (Wagenaar, 2012, 212). We use stories to explain why events happen, how we got where we were and why we acted in a certain way. Importantly we use stories to convince, give advice and persuade others of our point of view.

Because stories can be open ended, and are constantly updated in light of new information, they provide a way to reflect how reality is experienced, as opposed to how it is theorized (Wagenaar, 2012, ch.8; Bruner, 1992). The content of a story signals to the reader how the narrator constructs their reality, and shows the taken for granted underlying normative judgments about how reality is, and should, be perceived (Bruner, 1992). By using multiple stories to explore underlying normative judgments about the reality of a situation, event or policy, it is possible to see where those stories converge (and therefore speak to a unified belief) and where they counter (and therefore highlight contested normative judgments).

Further, stories have emotional impact and therefore: "*A good story makes us care about its subject…historical storytelling helps keep us morally engaged with the world by showing us how to care about it and its origins in way that had not been done before*" (Cronon, 1992, 1375-5). Where we place characters, the emphasis we have on certain characters, and the lack of certain characters all point to the '*realm of moral concerns*' (Wagenaar, 2012,p. 213). "*Characters in stories are moral constructions that indicate our beliefs about how people fit into society"* (Bruner, 1986, 39). This was particularly evident in my participants stories - the stories relating to drug use, or responses to drug use and resulting harms, were often spoken using language which highlighted the participants feelings of anger or betrayal at the lack of concern by the institutions, the wider public or politicians. While not always explicit, the stories showed a deep undercurrent of compassion and concern for the wellbeing of individuals and society. For example, the following story is about one of my interview participants first contact with a heroin user. The participant is a G.P., and will be introduced in the methods chapter, but here I use this vignette to show how the stigma towards drug users can be embedded within institutional settings:

> "*But I do remember when I was a junior doctor, the first time I really ever came across a recreational drug user, or whatever you call it, was a girl who is in the ward, a young, very young attractive redheaded girl who had asthma, and she had a bad asthma attack, or maybe she had pneumonia I can't remember. Anyway she had a chest problem, it was a chest clinic, and she was in overnight, and then she told me she was using heroin, you know I said what's all this injection site stuff, and I was again thinking, why would a pretty girl like that use drugs, you know. And again I was totally naïve and totally sort of, you know, she was perfectly clever nice bonnie girl, and I said to her you know you've got to stop, and what can we do to help. I spoke to the consultant and he said oh for Christ sake get her out of the ward, get her out, you know. And I said but you know she's ill, she's needing some heroin, and he said give her some heroin and get her out of the ward. So I gave her some*

heroin and she pushed off and I never saw her again. And I thought well that's a pretty feeble approach you know from the medical profession, so I spoke to some of my colleagues in psychiatry and they said oh you know, we don't do treatment, and they had a methadone clinic but, I never heard from her again" (Senior Drug Advisor).

A simple reading of this story highlights the empathy the narrator has towards the heroin user. Terms such as 'very young attractive redhead girl', and 'perfectly clever nice bonnie girl', show his need to describe her in what he considers a good light (although a deeper reading would analyse the use of the arguably patronizing and patriarchal based descriptions), cementing his belief that his profession were not treating her appropriately. The way he recalls the response of his colleagues also highlights the contempt he felt was directed to heroin users, and in his words the 'feeble approach' they had. This vignette is used to demonstrate on a surface level how the content of stories, and the emphasis put on characters, can point to the moral concerns of the narrator. As Wagenaar (2012) states: "*Our concern with a character when we listen to a story always points to a concern with the larger issues at hand, usually a breach of or threat to the accepted order of obligation and responsibilities. To the moral order in other words.*" (p.213). Equally the concern with a character by the narrator often points to a concern about a broader breach of obligation or responsibility, as demonstrated above.

This moral concern is evident in what Deborah Stone describes as 'policy stories'. In her book, The Policy Paradox (2002) she discusses two broad narratives that are prevalent in policy: "*the story of decline"* (it was once good but now it is bad, and only going to get worse if we don't do something about it); and "*the story of helplessness and control"* (it was out of our control but now we have found a way to bring it into our control) (Stone, 2002, ch.6).

The decline story is present throughout drugs policy, and most obvious in the story of rising drug deaths. Part two of the thesis charts this story, but briefly the story goes 'drug deaths are rising, we need to do something about it, we have a new initiative/tag line/bit of money, we are now in control'. This leads onto the second story, control. The underlying theme in the control story is the move from fate to control over destiny. Variants include *conspiracy* - where those who have control are misusing it to the detriment of the broader populace, and *blame the victim* story (Stone, 2002, p. 144). In the latter variant the victim is painted as the perpetrator of their own downfall, and this is evident in the overarching narrative surrounding 'problem drug users'. 'Problem drug users' are often seen as people lacking the commitment or will to stop using drugs: "*what all these stories of control have in common is their assertion that there is choice*" (Stone, 2002, p.144). The story goes 'we will provide individuals with the means to take control over their lives and they will be responsible'. The two often interweave together. First it is the story of decline, and then the story of control: the way we will climb out of the decline (Stone, 2002, ch. 6).

Stories in Policy: The Personal is Political

Policy stories are often referred to as policy narratives (Roe, 1994; Stone, 2002), yet for clarity I have attempted to separate the two. Policy stories are the stories told by individuals when describing or relating an action. Policy narratives on the other hand are the overarching narratives that encompass the multiple individual stories to make a larger, broader master narrative. For example, the story of decline described above can be related to an individual's story (she was once good but now she has an addiction) as well as a broader narrative about drug users (they were once good but now they have an addiction). These overarching narratives are used to underwrite and stabilize policy decisions on topics which have uncertainty, complexity and disagreement at their core (Roe, 1994, ch.2). However, these policy narratives often reveal deep power inequalities embedded within personal responses to policy. As Ettore comments: *'[w]e transform our personal stories into political realities by revealing power inequalities inherent in human relationships as well as the complex cultures of emotions embedded in these unequal relationships'* (2017, 2).

Importantly, policy narratives are often intractable and impervious to empirical evidence because they contain stories which resonate with the narrator, or constituent, as Roberts (2016) explains: *'Policy narratives possess significant institutional characteristics in so far as they constrain political actors 'thoughts and actions' by limiting the possible ways of viewing that issue'* (84). In the face of critique they become more embedded because, while critique is essential, it creates uncertainty and instability, two things that policy makers loathe (Roe, 1994, ch.2; Stone, 2002). Because stories provide such an important role in representing human action and problem solving, countering a policy narrative cannot merely critique the story, it needs to provide a new, better story that competently challenges and replaces the original narrative (Wagenaar, 2015, ch.8; Roe, 1984, 40 for similar vein of thought). This counter narrative needs to be as effective as the master narrative and follow similar plot lines for it to usurp the master narrative.

When competing narratives are difficult to read, or do not have a coherent structure to them and are a series of critiques, policy makers will fall on ambiguity and harden the master narrative line, because this provides security and strength to an issue which is complex and full of risk (Roe, 1993; Stone, 2002). It is argued therefore that policy analysts should focus on the structure of the narratives, both master and counter, and explore the similarities and differences in order to craft an alternative story that deals with the uncertainty and risk inherent in all complex policymaking (Roe, 1994, ch.2). Using personal stories to highlight policy narratives (both master and counter) allows the researcher to craft *meta* narratives that speak to both the policy making community, and the wider stakeholder community.

One of the challenges in identifying counter narratives is distinguishing between counter narratives and critiques. Policy narratives are stories that are used to underwrite and stabilize policy decisions on topics which have uncertainty, complexity and disagreement at their core (Roe, 1994;

Stone, 2002). Critique can be used to counter master narratives but they are not stories because, while they may have a plot with characters, often closely aligned to the critiqued policy, they take the policy point by point and argue it down but never offer any solution. In short they don't have an ending, and therefore tell us what we should be against, but don't provide an answer for what we should be for (Roe, 1994), or 'what is' (Fischer, 2003). This is not always the case in drugs policy: many critical drug scholars critique drug policy and point to other frameworks such as decriminalisation or legalisation. However, where they often fall down is the lack of a simpler, coherent story that can compete with the master narrative that 'drugs are bad, that's why they are illegal'.

Further, the master narrative often concerns risk, and the story is highlighting the risk of something and how it can be managed. Where counter narratives can fail is in not taking account of the risk inherent in the story, or by highlighting their own risk but not providing a strong narrative to counter it. The perception of risk and how to manage it is crucial to policy decisions, and by extension policy stories (Roe, 1994). For example, as this research will show, with drugs policy it is the risk of harm posed by 'problematic drug use' that underwrites the responses to it.

> *'From a narrative analytical viewpoint, the more asymmetries between narratives in difficult policy issues, the greater the uncertainty and risk associated with those issues. The potential for uncertainty or risk increases when one of more of the competing narratives is not really a conventional story at all but rather a critique. At best, critiques leave unaddressed the palpable need of government officials and politicians to have a storyline when faced by what they do not know, or cannot otherwise analyse and justify. At worst, critiques serve only to intensify the ambiguities of an issues'* (Roe, 1994, pp.74).

However, while Roe is correct in stating that critiques can have a destabilizing effect, in some policy 'problems' that is the intended outcome (Fischer, 2003). Further, critiques are a form argument, and arguments underpin most policy initiatives (Stone, 1998; Majone, 1989; Fischer, 2003). Critiques focused on a local/national 'problem' may be part of a larger international or global narrative, or argument, which may provide certainty and strong counter narratives, but in the context of micro debates serve only as critiques (Fischer, 2003). Roe's analysis does not adequately account for the wider structural and global influence, nor does it account for the dialectal and narrative quality of policy debates (Fischer, 2003, ch,8). Critique is essential to challenge dominant practices however, therefore ways to critique, while also providing alternatives that do not destabilise, are important.

Narrative Interventions

A way of critiquing that can also be transformational is the concept of narrative interventions. These interventions use narrative in order to change the perception of a

situation/individual/group or action. Narrative interventions can be used to impose a particular narrative on a marginalised group in order to make it conform and '*[t]hus, narrative interventions can, in Bourdieu's terms, do 'symbolic violence' through the imposition of dominant discourses onto marginalised populations*.' **(**Fleetwood, 2016**,** 187**).** Further**,** Fleetwood gives examples of research on how alcohol drinkers have incorporated the bad side effects of drinking too much into their own 'hilarious' stories, suggesting that public health campaigns that highlight these negative effects may not work. Similarly, my masters' research into the effectiveness of Scotland's public health campaign on cocaine found that elements of the message increased a desire to try the drug (Ross, 2014).

However**,** Fleetwood (2016) discusses the role of narrative interventions in changing the harmful discourse, as opposed to the perceived harmful person, which has relevancy for drugs policy, and in particular this thesis. By challenging the narrative that exists, whether it is the use of language or collection of stories to describe a person/event/action, and replacing that language/story with a different one that does not marginalise or harm the group, there is a possibility of critiquing the policy and providing an alternative narrative that changes the framing but does not destabilise the framework.

The Research Gap and the Research Design

Although drugs policy, national and international, is a well-researched area, there is very little research into drug policy communities as defined in this chapter, and no previous studies which fitted the context. While there is research into drug policy formation in Australia (Ritter, 2009; Bacchi, 2018; Lancaster et al , 2018), the UK (Stevens, 2011; MacGregor et al, 2014; Nutt, 2010) and at a European level (O'Gorman *et al.*, 2014; van Amsterdam *et al.*, 2015), these studies focus on how policy is formulated top down: problem, statement, consultation, legislation and implementation. Research has highlighted the problem of translating policy research into policy formation (Ritter, 2009), explored the construction of drug policy 'problems' (Bacchi, 2012; Lancaster, 2014; Stevens, 2019) as well as more nuanced assessments of how drugs policy is constructed using harm indexes (van Amsterdam and van den Brink, 2010; Carhart-Harris and Nutt, 2013; Rogeberg *et al.*, 2018). However, to date there has only been one study which looks at the narratives underpinning drug policy formation in the UK, and this is focused on a small group of policy makers in a UK Government policy department examining the role these narratives play in the use of evidence (Stevens, 2011).

My research however seeks to go beyond the formation of policy at the top level and find the underlying narratives which guide Scottish drug policy, and those involved in the policy process. It uses Carol Bacchis analytical tool 'What's the Problem Represented to Be' (WPR) approach to explore the problematisation of drug use and users, and to develop a critical analysis of drug policy in Scotland. Furthermore, in developing the narratives it introduces a new and more

expansive understanding of narrative in social research, by explicitly combining multiple narratives and stories to create new meta narratives that show ways in which policy can be implemented as equitably as possible. It explores how Scottish drug policy can be best understood as emerging from the policy community in Scotland: that personal stories and collective journeys have resulted in a policy landscape that is focused on the health of its citizens, as opposed to an ideological stance (Stevens, 2011).

In order to encompass the different methods and analytical tools used in the research I used Interpretive Policy Analysis (IPA) as an overarching researching design. IPA is a research paradigm which combines interpretive approaches to social sciences and public policy analysis (Wagenaar, 2015; Yanow, 2000; Colebatch, 2002). It grew out of the interpretive movement in social policy and allows for multiple approaches to the research design, methods and analysis (Yanow, 2000; Schwartz-Shea and Yanow, 2012; Wagenaar, 2015).

Interpretive research is founded on the philosophical approach of hermeneutics and phenomenology (Bevir, 2000; Wagenaar, 2015; Blaikie, 1993). Phenomenology is a philosophical approach which argues that human consciousness exists because of perceptions, and these perceptions appear to us as phenomena (Yanow, 2000; Wagenaar, 2015). Philosophical hermeneutics is a development of classical hermeneutics; a theory for interpretation, specifically biblical texts, in order to develop understanding and meaning. Philosophical hermeneutics has a long history of development (Gadamer, 1960; Safranski, 1999; Wagenaar, 2015, ch.4) which I will not explore here. For the purpose of setting out my research design, it is the role of the hermeneutic circle in illuminating the whole by exploring the individual parts that I am interested in (Schwartz-Shea and Yannow, 2012; Gadamer, 1976). The hermeneutic circle describes a way of developing understanding and meaning by expressing "*the idea that there is no fixed starting point for inquiry: the process of sense making begins wherever the individual 'is' in her understanding at that moment, with whatever grasp of things she has at that time*" (Schwartz-Shea and Yanow, 2012, 30).

I structured my data collection starting from the principle that I had prior knowledge resulting from my involvement in the field (Perigrine Schwartz-Shea, 2012; Wagenaar, 2015). However, I intuitively turned the hermeneutic circle into spiral, as I could not relate to the closed circuit of the circle. I saw the process of transformation as a continuing spiral of knowledge formation, and was pleased when I came across Cerwonka and Malkki (2007), who describe the process of research as "*more spiral in nature than linear and cumulative*"(12). Similarly, Schwarts-Shea and Yanow state "*the resulting research style is better conceived of as a spiral than a circle*" (2012, 31). In the context of my evolving understanding of meaning, the hermeneutic spiral presented a visual representation of the way in which my mind gathered information, and therefore was the best fit (see diagram 1 below).

Diagram 1 – Hermeneutic spiral research. Design by Anna Ross

From this I worked from the basis that there were phenomena to be explored by following the hermeneutic circle (or spiral) of re-evaluating my research questions as I conducted my data collection and analysis. Importantly I was following the hermeneutic approach of seeking to understand motives, meanings and perceptions (individual subjectivities) in order to find a common whole (Yanow, 2002; Gadamer. 1976). The idea was that through this I would be able to explore why some evidence is used and some not, using the biographical data generated by my interviews with policy makers. However, by constructing my initial research question around puzzles that I had identified, with the help of my prior knowledge and literature on the subject, it became evident that I had limited my focus to an area which I felt was important, but which my data had begun to show me was only part of the picture. This is an important process in interpretive research, and helped to reformulate my research questions, and hone the focus of data collection going forward. As the research progressed, I incorporated dialogic meaning into my data collection and analysis.

One of the challenges I had using IPA was that the policy world I studied is so broad that it encompasses multiple actors, multiple communities and a variety of potential objects of study. While the focus of IPA is on policy worlds (as opposed to policies in and of themselves), I was initially overwhelmed by the vastness of the community. This led to a research design which at times felt messy and unstructured, yet the iterative process which arose from the messiness helped

to hone the focus of the research, and highlighted shared meanings and narratives which would not have been evident had I chosen a more top down structured thematic approach. One way I did this was to tighten the focus of the 'drug policy community'. I chose to focus it down to immediate actors, people who are/were involved in working in the drug policy field, or the wider academic, professional, activist arena.

There were three important aspects to my research which led me to conduct my research using interpretive policy analysis: context, choice of research methods and the potential for transformational outcomes.

1. Context

As demonstrated above I was, and am, deeply involved in drug using and drug policy communities in Scotland, and any design needed to reflect that. Context in this case is described as knowledge and experience gained as a result of previous immersion in the field, and can also be described as 'local knowledge' (Yanow, 2000), background knowledge (Wagernaar, 2015) and situated knowledge (Haraway, 2006; Fricker, 2013; Grasswick, 2018), although the latter two encompass more than just immersion in a particular field.

2. Research Methods

At the same time as starting my PhD I was also in the process of setting up a conversation group with drug policy stakeholders, with a view to creating dialogue between different drug policy communities. The rationale behind this was the desire from many quarters to start talking, and doing drugs policy differently. This, combined with the opportunity to access important stakeholders for interviews, my immersion in the wider drug policy community, and the recent change in Scottish drug policy resulting in events highlighting the Scottish Governments narrative, meant that I wanted to encompass a variety of data collection methods. IPA, with its flexibility in methods, and focus on getting an in depth understanding by utilising multiple methods (Schawartz-She & Yannow, 2012; Yannow, 2000) seemed a very good fit.

3. Transformational Aims and Outcomes

One of the most important aspects of my research was my desire to produce transformational outcomes through the use of dialogue and shared stories. When I started the research I was concerned with this stance because I had yet to fully explore the role of critical studies, IPA and WPR Approach. However, it was the following quote which made me understand that my approach to policy analysis was best suited within the IPA discipline, and in particular the dialogic approach articulated by Wagenaar (2015):

> *"[t]he task of the analyst is to create a situation of "collaborative dialogue" (Innes and Booher, 2003, 2010) in which the stories of the contending parties become gradually more complex and inclusive to create a joint platform for action"* (Wagenaar, 2015, 221).

Using dialogue as a transformational tool became a fundamental aspect of the research and built on existing developments in this discipline (Way et al, 2015; Barge, 2002; Wagenaar 2015). IPA allowed me to incorporate the stories and narratives that emerged from my data and transform these into policy (and sociologically) relevant contributions to knowledge.

Research Questions

Research Question 1

'What are the master and counter narratives within Scottish drug policy communities?'

By using narrative to highlight the impact specific knowledge and histories have on policy formation and why certain individuals become involved in this area, it was hypothesised that there are two competing narratives informed by the history of public health and criminal justice interventions around drug use in Scotland, originating in the HIV crisis of the 1980s. This means that the formal focus on harm reduction and recovery in drug policy disguises fundamental disagreements about criminal justice and drug treatment practice. Question 1 was designed to explore this hypothesis and highlight whether there are shared narratives which will enable these communities to work towards an understanding of different concepts of drug related harm, and solutions stemming from this.

Research Question 2

'What are the challenges in engaging different epistemic communities in a participatory policy process?'

A further research question was on the participatory aspect of the research. Initially this question was seeking to explore why stakeholders such as drug consumers were not being consulted or engaged in drug policy development. This has changed due to the Scottish Government making a commitment to engage drug consumers (and a broader range of stakeholders) in drug policy deliberation. However, the question remains pertinent, with focus on how meaningful that engagement is, thereby highlighting the challenges in participation.

Research Question 3

'What is critical drug theory, and how can it help us understand drug policy formation in Scotland?'

Finally, as a result of using grounded theory to initially analyse my data, and the WPR approach to critically analyse in more depth, I developed the beginning of a theoretical framework I call 'critical drug theory' (CDT). CDT is a development of critical theory, in particular critical race theory (CRT), that argues drug policy reflects a certain world view, and by extension discriminates against those who challenge this world view. CRT uses a counter narrative to challenge dominant discriminatory narratives, and I developed the narrative arm of CDT as a result of hearing and experiencing these counter narratives throughout my data collection. The question for this thesis is, can this theoretical development help us understand the barriers to wider participation, and the underlying narratives that exist within Scottish drug policy communities?

Summary

This research grew out of my perception of personal troubles that transform into public 'problems'. It starts with myself, the researcher, experiencing and seeing the personal impact that the drug laws have had on myself, and my community. While it may 'only' be my perception that these troubles have been caused or exacerbated by the drug policy framework, it nevertheless represented my, and many others, reality and therefore needed to be explored. What was surprising about listening to the public narratives (in the form of the data I collected) was that many of my own concerns and private troubles were reflected and co-created by the participants - from interviewee and observational data - many of whom I did not expect to share the same reality with. By having shared experiences with the research participants, I was more able to fully understand their construction of the 'problem'. The following chapter sets out the methods I used to explore the reality of both the participants and myself.

Chapter 3

There are Methods to this Madness

> *"Methods purport to function like instructions. That, after all, is their whole idea. They tell you how to go about doing research. But here we run into a huge paradox. The instruction is meant to set the novice on the proper path, yet he only grasps what the method is about after he has found and walked the path himself. The paradox is that instructions are not beginnings, but rather the endpoints of a long process of socialization in which instructions are not much use because the novice doesn't have the body of experience to interpret them properly"* (Wagenaar, 2015).

This, in a nutshell, was my process. In way it is like learning how to cook. I spent several years as a chef, but before I did I was often impressed at how some people just 'knew' what to add to a meal to make it taste good. When you are cooking you follow the recipe, and if you have never cooked before you follow it blindly, with a view to replicating the recipe as closely as possible. Once you are confident in cooking you start to add a little bit here, a little bit there, and the instructions act as guidance, as opposed to a strict rule. I spent a large portion of the PhD following the different instructions surrounding all the various methods I came across throughout the process, yet it was not until I had nearly completed the thesis that I began to truly understand what I had used, how I had used it, and how it enhanced (or tainted) the 'flavour' of the data. However, I would add that this socialization path is essential and should not be viewed as daunting. Through my grappling with different methodological concepts, methods, theories and frameworks, I began to see the wood from the trees, and understand which processes fitted both the research topic, and my own research style.

As demonstrated above, I did not come to this topic with a clean slate. While arguably no one comes to a research topic with an empty mind (Charmaz, 2006; Wagernaar, 2015), my background knowledge and presuppositions conspicuously steered the direction I was going. The challenge was how to design and conduct my research while taking into account this knowledge, incorporating it into the process yet not allowing it foreclose the possibility of discovery through the research. I overcame this challenge by using interpretive policy analysis (IPA), as described above, which allows for the incorporation of background/local knowledge and utilises a range of methods, and by having a deeply reflexive component to the thesis, thereby integrating my background knowledge and experience into the overall research design.

This chapter is divided into 2 sections. Section 1 will document how I generated the data. In order to explore this community in detail I chose to use multiple methods, partly as a pragmatic response to the different communities I sought to explore (policy makers, policy advisors, drug consumers, stakeholders more broadly), and partly as a result of conducting my research using

IPA. This multiple method approach is helpful when conducting grounded theory as it allows for multiple sites of selection, and builds flexibility into the design which allows for testing emergent questions in different contexts (Charmaz, 2004, Ch,2). My choice of methods was also influenced by the context in which I found myself and the availability of my participants. For example, I used purposive sampling (Ritchie et al, 2014, ch.5) to set the parameters for my interview participants, and accessed them through the networks and relationships I was cultivating as a result of the participant observation I was conducting (Ritchie et al, 2014, ch.5). Section 1 will therefore tease out an order from the intertwined data generation processes, and show how I managed to gather in-depth rich data on my community of study.

Section 2 will set out how I analysed the data using grounded theory, narrative analysis (Charmaz, 2004, Czarniawska, 2004, Daiute, 2014) and the WPR Approach (Bacchi, 2009). I started my analysis using grounded theory and closely followed the steps outlined by Glaser and Strauss (1967) and developed by Charmaz (2004) of close coding, thematic development and theoretical sampling. The analysis and data generation were iterative, and following this process I began to develop the framework of a new theory: critical drug theory. Theoretical development is one of the main outcomes of grounded theory approaches (Charmaz, 2004, ch.6) yet there is a danger of getting lost in the creation of grand theories in order to distract oneself from the messy business of data analysis (Wagenaar, 2015, ch.8). In this section I demonstrate how I came to construct this theoretical framework, and how it then helped me understand my data better, provide the structure needed to conduct narrative value analysis (Daiute, 2014) and uncover master narratives within my data. Furthermore, I introduce the WPR Approach and show how I used this to structure and analyse the narrative content of the data, present it in the following chapters.
Diagram 2 sets the methodological framework, and Diagram 3 visualizes the process of data collection and analysis.

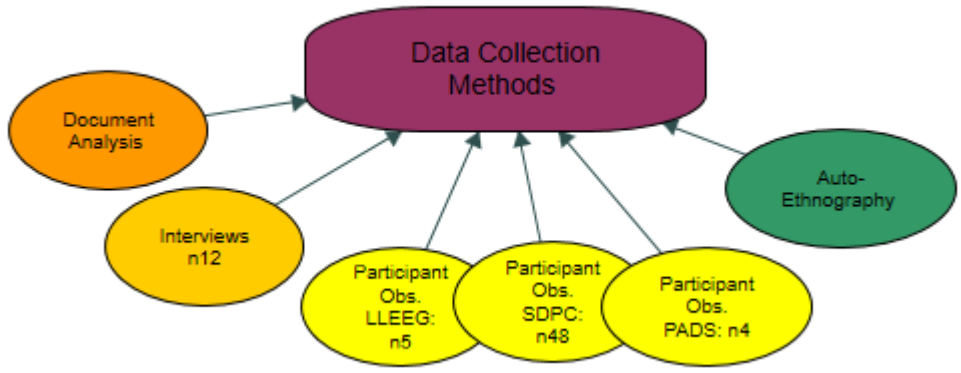


Diagram 2 – Methods. Design by Anna Ross

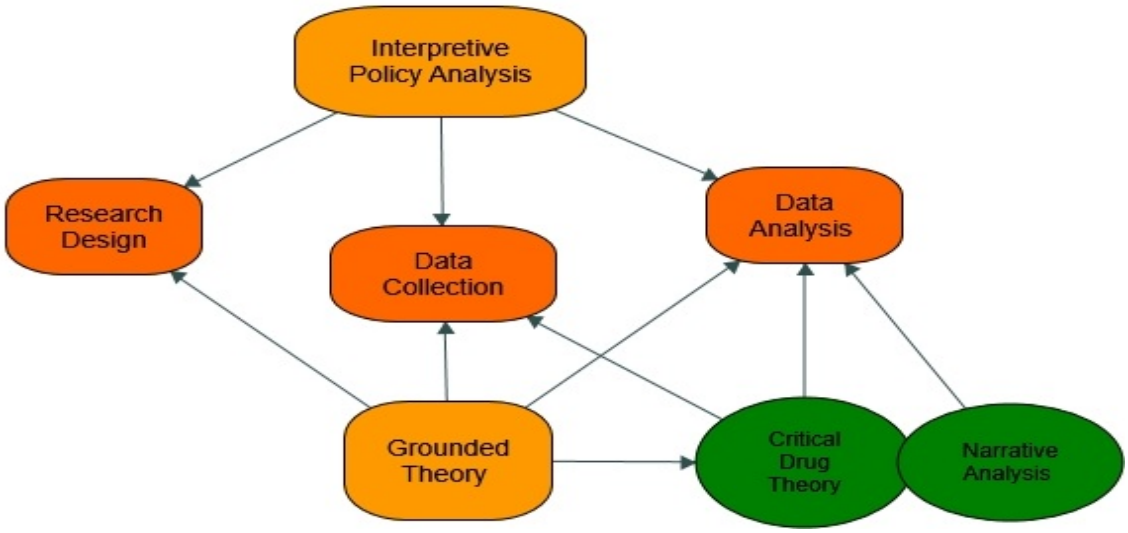


Diagram 3 – Data Collection and Analysis. Design by Anna Ross

Data Collection

In order to explore the current and competing narratives within Scottish drug policy communities I utilized a range of methods to 'access' a broad sample of data (Yanow, 2000, Daiute, 2014, ch.2). The core data for interpretive policy analyses are interviews, observation and document analysis (Yanow, 2000, ch.2; Wagenaar, 2015, ch.9) but, as Yanow (2000, 27) states:

> *"The "data" of interpretive analysis is the words, symbolic objects, and acts of policy-relevant actors along with policy text, plus the meaning these artefacts have for them…[i]n this sense, then, we might more properly speak of accessing the local knowledge that the analyst needs to make sense of a policy situation.*

I therefore sought to 'access' as much policy relevant data and context in order to create a deeper understanding of the narratives at play. Policy relevant data was determined by my research questions, in particular data that highlighted narratives and participation within the community such as observing at meetings, observing and taking part in stakeholder engagements, informal conversation between myself and stakeholders, official documents and interviews.

My data was a mix of naturally occurring and generated data (Richie et al, 2014, ch.3). Naturally occurring data refers to data such as documents, conversations, internet and other data which I came across (Ritchie et al, 2014, ch.3). Generated data is that which is generated by the researcher such as interviews, focus groups, and to some observational data (Ritchie et al, 2014, ch.3). The distinction between these two forms of data is not always clear cut, as will be explored below (Silverman, 2004; Ritchie et al, 2014, ch.3). The bulk of my findings came from my

interviews, and the development of critical drug theory arose from the iterative process laid out in grounded theory analysis (Charmaz, 2004). As stated by Wagenaar (2015) "*deep qualitative interviewing and the systematic analysis of interview data are the core business of interpretive policy analysis*" (251), and gathering rich data through interviewing (explained below) provides the researcher with in-depth understanding of the topic (Lofland & Lofland, 1995).

Document Analysis

Document analysis is usually the first form of data collection that an IPA practitioner starts with in order to provide an initial overview and understanding of the field (Yanow, 2000). This is not the literature review but rather documents which are produced by the policy community which shed light on what narratives are being used. They can be used to develop interview questions (Yanow, 2000) and can highlight gaps or discrepancies between observed or interview data, and the documents (Charmaz, 2004, ch.2). For example, the confusion around what a 'problematic drug user'actually is was initially highlighted to me in the strategy document, The Road to Recovery (2008). There is a lack of clarity whether a 'problematic drug user' is an opiate and benzodiazepine user, or a user of any drug who experience social medical, legal and familial issues resulting from drug use. This prompted me to explore this confusion in my interviews and observation.

I conducted selective document analysis primarily to highlight institutional narratives and responses. I have focused my attention on documents produced by the Scottish Government, because much of the institutional responses to drug policy stem from this source. In particular the following four documents are of importance to understanding the current policy narratives of the Scottish Government. I have included a non-exhaustive list of documents produced by Scottish administrations over the last 30 years in the appendix.

1. The Road to Recovery 2008 - Scotland's cross party drug strategy, due to be revised in the next year or so (speculative time date from policy actors within the government)
2. Right, Respect and Recovery (2018) - Scotland's most recent drug strategy document that builds on the Road to Recovery
3. Research for Recovery 2010 - evidence to support The Road to Recovery
4. The Scottish Framework for Problem Drug Use and Recovery 2015 - sets out the new advisory landscape set up by the Scottish Government in 2016

These are the core documents which the Scottish Government work from and use to support the current narrative. In addition to these specific documents I have analysed reports published by Public Health Information for Scotland[2] which is the new government body responsible for drugs

[2] www.scotpho.org.uk

research. I have also used the websites and associated documents of Police Scotland[3], NHS Health Scotland[4], Scottish Drugs Forum[5] and the Scottish Recovery Consortium[6]. The rationale for including the latter two is these organizations are the principle recipients of government funding for drugs and have been instrumental in providing policy advice over the last 10 years.

Interviews

As Rossman and Rallis (2003) state "*in-depth interviewing is the hallmark of qualitative research*" (180), and the purpose of these interviews in IPA is to "*obtain rich, detailed material that can be used in qualitative grounded-theory-type analysis* (Wagenaar, 2015, 252). I had originally intended to conduct a large sample of interviews (40-50) with a range of actors that had been identified as suitable respondents. However, after conducting the first interviews I realized that the research questions would be better answered by longer in-depth interviews. As Michael Erben (1998:5) argues:

> *"What the size of such an interview sample is should be dictated by the purpose for which the research is being carried out. The exact size of any sample in qualitative research cannot be ascertained through quantitative methods. It is for this reason that it is all the more important that the consciously chosen sample must correspond to the overall aims of the study."*

I therefore chose to limit my sample to 12 participants, in the desire to carry out in-depth narrative based interviews as opposed to a larger sample. This provided enough data that overarching themes and narratives were identifiable, while also providing data that was rich in detail (Ritchie; 2014). Further, using grounded theory from the start I was able to tailor my final interviews to provide an element of theoretical sampling (testing the theoretical construct that has emerged from the grounded analysis) (Glaser and Strauss, 1967; Ritchie, 2014).

Sampling: Community and Criteria

As Howard Becker points out *'[s]ampling is a major problem for any kind of research. We can't study every case of whatever we're interested in, nor should we want to'* (1998: 67), and this set the tone for my own sampling decisions. In order to define the sampling parameters within the broad definition of 'the Scottish drug policy community' I used a form of purposive sampling (Patton, 2002), also known as criterion sampling (LeCompte & Preissle, 1993). Purposive sampling is the process of selecting participants based on pre-determined criterion in order to ensure that there is broad coverage of the topic being studied (Ritchie et al, 2014, ch.5). A further

[3] www.scotland.police.uk
[4] www.healthscotland.scot/health-topics/drugs
[5] www.sdf.org.uk
[6] http://scottishrecoveryconsortium.org

refinement of this form of sampling is critical or typical case sampling (Ritchie et al, 2014, ch.5; Creswell, 2013; Patton, 2002). This form of purposive sampling is particularly suited to my research topic because participants were chosen on the basis that they have access to knowledge particular to the research topic. For this research the phenomenon being studied is the drug 'problem' in relation to policy development and participation, therefore I needed to sample generationally (people who were there at the time and now) in addition to people who had experience of both the policy development, and drug use or drug 'problems'. I chose to define drug policy formation on 2 levels; level 1 meant that respondents had been directly involved in creating policy (through government or an advisory committee attached to the government), and level 2 meant that the respondent had been involved in either an advisory capacity as an independent (academic or 3rd sector organization) or had been involved in the implementation of the policy (through a national or local agency). Drug use was not overtly sampled for, however I knew that several of the respondents had experience, and therefore knew that I was including this element when I chose to interview them. This restricted my potential respondents to those who had an in depth understanding of Scottish drug policy, and provided coverage of a range of levels within the policy process, as well as experience of drug use.

Access to participants was facilitated by my existing engagement with the Scottish drug policy community and my convening of The Scottish Drug Policy Conversations (SDPC - more below). The SDPC provided the networks and the opportunity to build relationships so that when it came time to request interviews from key policy stakeholders, I had a relationship based on trust with many of them.

A potential issue with this sampling technique is that certain narratives will be overlooked. For example, I only had one interviewee who argued that policy should focus more on criminal justice sanctions, although this narrative represents a large section of the Scottish public. This can result from the focus being narrowly defined to a small group of people active in the drug policy world, and can result in the exclusion of non-traditional policy voices, namely drug consumers. However, Scotland is a small country and policy makers/advisors are generally accessible to researchers and those within the academic community. With my background, or *situated* knowledge of this world (as demonstrated in the previous chapters) I was able to identify key actors who would be able to elucidate the current narratives at different levels of the policy process. Yes, certain voices were left out; in particular those who did not engage with the SDPC, third sector organisations who work with drug consumers, those whose specific focus would have been drug consumption, and direct interviews with civil servants (although I made several requests for interviews). Yet it is not possible to have complete coverage of such a vast topic (see further Becker, 1998, ch.3): my research was looking to explore broad narratives surrounding drug policy, and the data I did collect allowed me to do this.

On the other hand, I approached my research with the understanding that the distinction between drug consumers and drug policy actors is false. By approaching it in this way, I created the space for policy actors to be honest about their current or past drug use. Not only did I have participants who had or were currently using drugs, but also a range of drug using experiences, from what could be termed 'problematic' to 'recreational', thereby covering a range of experiences. Below is a table setting out the name and details of those I interviewed. I ascribed each interviewee a number which will be referred to when quoting. There was varying levels of anonymity consent so some interviewees are only ascribed a number and a general description of their profession.

Details	Interview name
Policy Officer for a third sector organisation focussed on drugs.	Senior Policy Officer
Addiction psychiatrist and Scottish Government advisor from 1998-2015.	Drug Policy Advisor
Public health worker and advisor on Scottish Government drug policy committees.	Public Health Worker
Senior civil servant at the Scottish Government.	Senior Civil Servant
Minister for the Scottish Parliament from 2007-2014.	Ex Scottish Minister #1
Retired Police Officer working for Police Scotland and the Serious Organised Crime Association. Now deceased	Retired Police Officer
CEO of a third sector recovery based charity.	CEO of Drug Charity
Long history of local government involvement, part of the original Alcohol and Drug Partnership development, instrumental in the development of Scotland's Road to Recovery strategy. Retired.	Longstanding Government Advisor
Ex government advisor and part of the development of the current drug strategy.	Ex Government Advisor
GP and senior advisor to the Scottish Government for over 30 years. Chair of various sub committees. Since retired.	Senior Drug Advisor
MSP 1998-2007.	Ex Scottish Minister #2

Ethical Considerations

Before I recruited interview participants I applied, and was granted, ethical approval from the School of Social and Political Science at the University of Edinburgh. While I did not plan to interview minors or those considered vulnerable, I requested a higher ethical approval because

there were questions regarding drug use that may have brought up traumatic memories, in addition to disclosure of current or previous criminal activity. As it was there were two interviews which resulted in the participant disclosing traumatic past experiences, however the participants did not appear to find this experience difficult, although I cannot know for certain whether this is the case, and it served to provide context to their broader life story. In addition, several participants disclosed previous or current criminal activity (drug use), with one asking that their disclosure be completely anonymous. This caused slight difficulty given the small sample number, however I circumvented this by having all quotes completely anonymised, and participants were happy with this.

In regards to confidential storage of personal data, I recorded the interviews on a digital recorder and stored the recordings on my password protected computer. Once I had transcribed the audio I destroyed the recordings.

Gaining Informed Consent

I recruited most of my participants by asking them in person whether they would be willing to be interviewed, and I followed this up with email communication to arrange a suitable date and place. The remaining participants were recruited via email due to distance and not having the opportunity to meet face to face. All my interviewees were given a participant information sheet (see appendix A) which informed them of the nature and scope of the interview and research, and were asked to sign a consent form which specified various levels of anonymity (see appendix B), an 'opt-in' approach (Ritchie et al, 2014, ch.5).

All of my participants agreed to allow full disclosure of name, position, age and gender, apart from one who felt her current position did not need to be known as the interview was based on her role as manager for the Scottish Government Drug Policy Unit, a position she no longer held, and another who did not want their name disclosed. Incorporating these requests into the data opened up the ethical consideration of representation. When one set of respondents wish to remain anonymous, it follows that those who are not anonymous have their voices heard more clearly. This can be an issue if we are anonymising groups that traditionally have little representation such as drug consumers, however in this research those who requested anonymity were in positions of power. Representation is therefore not so clear cut, but the desire to remain anonymous when talking about sensitive issues such as drug use, or the workings of government, highlights the challenges in creating open and transparent spaces that can break down boundaries and reduce stigma, an underlying aim of the research.

Interview Questions

All of my interviews were semi-structured and used open-ended questions. The first seven interviews took place over the winter of 2016/17. Analysis of these interviews, combined with my

emerging themes from field work, observation and document analysis, resulted in the emergence of the theoretical framework of critical drug theory (CDT). The next five interviews were similarly structured but additional questions were asked in order to test the emerging theory (Glaser & Strauss, 1964; Charmaz, 2012).

I was interested in participants' life stories, partly as a way of immersing ourselves into a conversation, and partly because I had a hunch that background experience of drug use impacted the narrative individuals later used when talking about drug policy. I therefore conducted the interview as a conversation, with the participant leading by telling me where they were from, where they grew up, and first experience of drug use (personal or through family and friends). Interestingly the opening question 'so tell me bit about yourself, where you were born, where you grew up', elicited a surprised response from many of the participants, for example *'early life? Wow…how unexpected!* (Interview#3). It appeared that because of the topic and the relationship I had built with many of them, they were expecting to talk about the process of policy making and politics, as opposed to who they were and where they came from. Opening the interview this way settled the participants into the rhythm of the interview, and helped bolster an atmosphere of trust by engaging with their personal story.

Although I had created my interview guide, I found there were five questions that steered the direction of the interview:

1. Tell me a bit about your early life. Where were you born, where did you grow up?
2. When was the first time you came across drug use?
3. How did you become involved in the drugs field?
4. How would you describe drug users?
5. How would you describe drug related harm?

REFLECTIONS ON INTERVIEWING

With my interviews, I feel that I created that relaxed space most of the time, indeed I feel potentially I was too relaxed and informal, allowing the interviewees to guide the topic, as opposed to me asking lots of inquiring questions. Often I would pick up on a topic or something they had said, and at the right moment I would take them back to it. But listening to my interviews as I transcribed them there are often moments which I wished I had probed a bit deeper, or gone a bit further, as this would have given me insights that I would not be able to get outwith that setting. For example, conversations on certain individuals/policy and how they interact with them may have flowed freely after one hour of sitting talking and laughing and building a rapport, but it is not the kind of thing I can email for a follow up, as they would not be so forthcoming, remembering that the information is being use to scrutinise and analyse that topic. (**Reflective diary,** spring 2018)

With these five questions I was able to move through their lives, dipping in and out of certain parts of their narrative, and building a broad picture of the individual, as well as the policy realm they inhabit(ed) (Rossman and Rallis, 2003, ch.7). As with most of my methods I engaged with the interview process using dialogic techniques, creating a conversation with my participant in which both of us developed a deeper understanding of the topic being discussed (Rossman and Rallis, 2003, ch.7; Way et al, 2015). What resulted was a "*transform[ation of] information into shared experience*" (Denzin, 2001, p. 24). An example of this can be seen in the following extract:

> *Ex Scottish Minister #2 I don't like the term problematic drug user, because who defines what the problem is, I don't like the paternalism that that it implies I suppose. But without question, again quite a common sensical way, you know you see people that, you know, just in a bad way…*
>
> *Me: I like the term chaotic drug user, because that kind of describes a reaction which encompasses a wee bit more of the kind of people that we're talking about, which is somebody who is unable to sustain you know that sort of normal lifestyle so to speak…*
>
> *Ex Scottish Minister #2: yeah it's interesting that you kind of put that in front of me, you've prompted me… I've never thought about it that way before but, again you're right, I suppose [long pause] I'm much more concerned I suppose about where people aren't able to manage their lives, than where they are.*

Many of the questions I planned to ask were addressed by the participant before I had a chance to ask them, and the natural rhythm of the interview brought out the themes and ideas that were beginning to emerge in my data as the process gathered pace.

The Rhythm of the Interview: Monitoring the Quality

One of the hardest aspects for me as an interviewer was monitoring the quality of the interview and making sure that I came out of the interview with in-depth data to take forward. Because I had developed a prior relationship with most participants they were aware of my opinions on the topic, and we had already established a rapport. As Way et al (2015) discuss, dialogue can be used as a transformative tool, not only eliciting knowledge from the participant, but also creating the conditions for the researcher and the participant to explore their similarities and differences in a respectful and thoughtful manner (Way et al, 2015; Barge 2002). This was evident in much of our interaction, with either myself or my participant mulling over points and reflecting on points. Cunliffe (2003) encourages this form of collaborative meaning making between researcher and participant because it allows us to 'question the distinctions we make between what is fact or fiction, the nature of knowledge and ultimately our purpose and practice as researchers'. (985).

Yet, as Wagenaar points out "*a research interview is not a conversation with a friend"* (2015, 253), and there is a balance to be struck between creating the conditions for transformational dialogue within the interview setting, and having a chat.

Transcription

I decided to transcribe my interviews verbatim in order collect all the data in the interview (Charmaz, 2006) and allow for surprise (Wagenaar, 2015, ch.9). One of the most surprising outcomes however was the insights I gained regarding my interviewing style, and the way in which we interacted with each other during the interview. I noticed that at the beginning of the interview I listened to the participant with very little interruption except for clarification points and to guide them back to the original question. However, as it got more in depth I found myself interrupting sometimes in order to put an idea across (a big no no according to Wagenaar, 2015, 257), or narrate a story which was pertinent to what they were discussing. While this may have helped to create the condition for transformational dialogue, there was a danger that I was steering the tone of the interview to suit my interpretation (Wagenaar, 2015, ch.9; Ritchie et al, 2015, ch.7). Interrupting the flow of the conversation can prevent the participants from reflecting further on the topic (Way et al, 2015). In my early interviews there were occasions where my participant came back to the topic stating, "*as I was going to say*…"

However, using the iterative process I started transcribing immediately and was able to pick up on these issues to adjust my technique moving forward (Charmaz, 2006, ch.2, Schwartz-Shea and Yanow, 2012, ch.2).

During the transcription process I decided that while I would disclose who I interviewed and use full names and positions, at times I would anonymise the answers. I discovered during the transcription process that many of my interviewees had relaxed during the interview to such an extent they disclosed stories about themselves and others they may not have originally intended to. There were several 'off the record' comments, and indeed, when I informed participants that I planned to anonymize parts of the transcripts several were relieved, knowing they had disclosed more than they had intended to. In the end I have not used anecdotes or stories that I felt the participants would not have felt comfortable with. Ethically and morally this feels the right thing to do.

Continuing the Communication

Because my relationship with my respondents went beyond the interview space I was able to create ongoing communication with them, and to contact them for any clarification or elaboration on areas covered in the interview. Many of the respondents were also part of the SDPC, and so my observation of the narratives within that group were added to the interview data using

field notes from the SDPC sessions. Although I offered to send the completed transcripts for them to read over, no one wanted them, with one participant expressing relief that I had not sent it as he was afraid of reading his responses.

However, one of the issues of using so called 'elites' - or rather those with very busy lives and willing to give you an hour of your time and no more - is that because the research question is open, I found there were questions I wished I had asked but I was unable to return for a second reading, so to speak. For example: one of my first interviewees is a well known ex-politician and professional, and when I conducted the interview I was still using the format of biographical interviewing in order to understand where participants came from, and asking about their experience of Scottish politics and drugs policy. However, my last interview highlighted the role this participant had played in the Royal Society of Arts report 'Drugs: facing facts (2007), and I would have loved to have gone back and asked for a bit more detail on the reception of the report and how it worked with the release of The Road to Recovery. This is not possible anymore because the participant was appointed to a high level policing job, and was unwilling to discuss any further involvement.

Participant Observation and Action Research – Blurring the Lines

An important data collection source was the policy group I helped to set up called the Scottish Drug Policy Conversations (SDPC). The following section explores how I approached this source, and the difficulty I had in clarifying the type of collection method.

Participant Observation

Observation is a central method in qualitative research, initially used as an anthropological tool, but now incorporated into many disciplines including sociology (Ritchie et al, 2014, ch. 9). Observation as an ethnographic tool involves observing the group, community, organization, meeting, and taking detailed field notes with which to analyse (Ritchie et al, 2014). There are various continuums first outlined by Gold (1958) ranging from complete participation to complete observer; the extent to which the researcher participates will depend on the aims of the study, and the conditions available to them (Ritchie el al, 2014; Schwartz-Shea & Yanow, 2012; Cohen et al, 2011).

For example, in 2008 Alex Stevens conducted participant observation in a drug policy unit of the UK Government (Stevens, 2011). Initially he had been seconded to work as an adviser to the unit for 6 months, and he saw the opportunity this represented to study the way in which evidence influenced policy. Realising that knowledge of his research would impact his findings he applied, and was granted, ethical clearance to conduct covert observation (complete observation). While the senior management of the unit was aware of his research, those he engaged with on a

daily basis were not. The result was a study which explored the competing narratives within the UK policy unit, and uncovered policy decisions which may not have been observable had the staff known he was conducting research. On the other end of the spectrum, Taylor et al (2004) conducted observation of injecting drug users in Scotland in order to better understand the route of transmission between injecting drug users. The researcher themselves however were not participants, they used video recordings of participants injecting drugs and analysed the recordings (Tayler et al, 2004). Observation therefore spans complete immersion in the field of study to external observation of the object of study. Use of observational data in this research ranged from complete immersion in the field to more passive participant observation of meetings, as explored below.

The Case of the Scottish Drugs Policy Conversations (SDPC)

In 2014 Scotland held a referendum on Scottish independence, which was not successful. However, the impact of the referendum inspired greater discussions on more powers for the Scottish Government, and in some drug policy communities the possibility of having more control over our own drugs policy. Myself and several other academics independently submitted proposals to the Smith Commission on devolution of the powers held under the Misuse of Drugs Act 1971. While nothing came of our submissions, myself and Mike McCarron (a long term public health and 3rd sector professional within the drugs field) developed the concept of the Scottish Drugs Policy Conversations, with a view to create a multi-civic led network to explore options for change in Scotland (see www.sdpc.org.uk). The development of SDPC is set out in the Appendix 2, including a breakdown of the different conversations held. More details of the conversation are explored in chapter 7.

The first conversation took place on the 25th June 2015 at the Academy of Government, and we have since held 14 sessions, with 2 more to be held in 2020. The initial meeting highlighted several important points that are recurring narratives within the drug policy debate.

> *"Overall most people have been open and excited about the prospect of being involved in a movement that may change the way in which drug policy is debated and talked about. There has been much conversation about why we are here, concerns that we have over current policy, representation of stakeholders and other issues detailed below"* (SDPC notes, 28th June 2019).

Methodological and Ethical Challenges: My Role Within the SDPC

When I chose the SDPC as an object of study I believed I would be engaging in participant observation: that I would be participating within the SDPC and using this position to observe and record information pertinent to my research. SDPC started at the same time as my research and

therefore my role within it had not yet been established. The complication arose as a result of my role within SDPC, and the move from behind the scenes convener and participant, to convener, facilitator, administrator and participant. Is it possible to call this participant observation when I am instrumental in creating the event, and setting the agenda for the meetings, in addition to steering the conversations within the space? Indeed I have not so much immersed myself in the community I am studying, I have created the community. It is possible that SDPC could have provided the opportunity to conduct action research. Although the development of the SDPC was spurred on by the commitment set out in my awarding of the Principle Career Development Scholarship, I did not foresee the SDPC becoming a space for action research because I lacked confidence in my ability as a facilitator and researcher, understandable given my limited experience in the field. As the research developed I began to understand my role within SDPC and the broader research process, reflecting a deepening understanding of the role reflection and deliberation play in creating meaningful spaces for dialogue and transformation. While there were intense life changes taking part outwith the PhD setting which added to my development, the process was initiated by an incident which took place on a course I attended. As part of the process of changing from activist to researcher and initiator of dialogue I went on a course on public engagement. It was a 2 day course designed to give you some skills in how to design and carry out different public engagement activities. As part of the group exercises, we took it in turns to facilitate and participate in an activity. It is perhaps most useful to read the reflections of this incident recorded at the time.

Reflections on day one

> *"This day mainly focused on dialogue and creating spaces for dialogue, active listening and group participation in facilitation methods.*
> *It was fascinating because I learned an immense amount about my lack of self-awareness when it comes to group interactions and dominating the conversation. Previously I had felt that I was good at being able to give space to those who wanted to talk but at the same time allow for those who are happy not to talk so much.*
> *In the facilitation group I became embroiled in a confrontational exchange with one of the participants who appeared, to me, to become fixated with this idea of getting everyone to input. Initially I was put on the back foot by him because he made a snarky comment about my style of facilitation which raised my hackles and made me lose confidence in my ability. He focused on the fact that not everyone was inputting, whereas my thoughts were that as long as the space was available, it was not appropriate to push everyone to contribute.*
> *If I had practiced dialogic techniques, I could have stepped back from his comment and looked underneath it. As it was, it meant that when he started pointing out that people were not getting a say, we entered into a kind of sparring of words. But I had no idea that this is what was being perceived by everyone else, and while I thought he was the protagonist it transpired that I was also the protagonist.*

> *Anyway, in the debrief it came out and it really shook me to the core, not least because it is something that Willy talks about regarding my ability to communicate, how I am sometimes completely unable to practice self-awareness. Very interesting and makes me realise that I am not quite ready to become a facilitator.*
> *Another outcome was the self-sabotaging techniques I appear to use such as flippant jokes or self-depreciation which have served me well in many group contexts but now just come across as unprofessional. I am learning how to don different hats and this will take time. Need to develop the ability to ACTIVELY LISTEN"* (Field notes from How to Design Public Engagement Conversations. 1st March 2016).

The result of this interaction opened up an aspect of myself which previously had been covered. It touched not only the way in which I dealt with professional and educational interactions, but also my personal relationships. I began an ongoing journey into the impact that preconceptions and a lack of self-awareness can have on the way in which I engage with the world. How I perceive the world impacts how I facilitate and guide the collaborative process that is SDPC.

SDPC provided me with a wealth of data, including access to interview participants that may not have been available to me otherwise. The data collected from the SDPC sessions included notes, in the form of written minutes of the meetings as well as personal reflections on the events and dialogues taking place, and photos and flipchart notes created by the participants during the sessions (see photos in Appendix 2).

Auto-ethnography

As discussed in chapter 2, I use an element of auto-ethnographic writing as part of the research design and a method of data collection. While there has been criticism that this form of data is narcissistic or self-indulgent (Ettorre, 2017, 359), I used this tool as a way of inspiring empathy with the reader, and bringing to the fore subjugated knowledge (Foucault, 1964). Auto-ethnography has gained traction in the last few years, partly in response to the ethical challenges of representing the voices of research participants, the imbalance of power that can exist between the researcher and the researched (Ellits, Adams and Bochner, 2011; Lapadat (2017). Auto-ethnography addresses these challenges by placing the researcher as a subject, and requiring analysis of that position as both researcher and subject (Coffey, 2002). Initially I planned to use auto-ethnography extensively throughout the thesis, however, in keeping with the iterative nature of the research design, in the end I used it sporadically throughout, and focused the main writing on one small chapter highlighting the hidden and silenced narrative of the 'happy' drug user. Therefore this writing, rather than being auto-ethnographic, is inspired by auto-ethnographic approaches, with some passages used to highlight aspects of the analysis.

Other observational/research action data

In addition to the data collected from SDPC I also observed other spaces which helped me build a picture of the narratives within the Scottish Government, and policy actors working within and outwith the government departments.

1. Reducing Harm and Drug Related Deaths Committee
   I attended one meeting of this committee as a researcher at the beginning of the data collection, however, as a result of the networks I generated while carrying out my research I became the 'lived and living experience' representative on this group. This presented a slight ethical challenge, and in order to circumvent this I chose to report only on the auto-ethnographic element of this experience, as opposed to some direct quotes I have used from the initial meeting.

2. PADS Executive Reference Group - Lived and Living Experience Group
   This was an advisory reference group, put together by the PADS executive committee to engage with people who have lived experience of drug users. It was an attempt to include non-traditional voices in the policy process and will be explored in more detail in my narratives section. I was invited onto this executive reference group as a result of my activities within SDPC, and my vocal support of reducing the stigma towards active drug users.

3. Scottish Government Substance Misuse Unit
   I held several meetings with the manager of the Substance Misuse Unit on a one to one basis, and with other civil servants. While the discussions of the meetings have been held in confidence, I have used the themes and views resulting from them in my exploration of the narratives in Scottish drug policy communities.

4. Medicinal Cannabis Reform Scotland (MCRS)
   MCRS are a patient led campaign group trying to be involved in discussion around cannabis for medical use in Scotland. I became involved as a peer stakeholder negotiator/mediator early on in the research, and this involvement became part of research. I set up meetings with civil servants, put on events, wrote letters and advised on communication.

Below is a table adapted from Dvora Yanow's little blue book on 'Conducting Interpretive Policy Analysis' (2015, p.39) that details the different sources and kinds of data I collected "*to create a Picasso like portrait*" (ibid, 38) of the policy community I was studying.

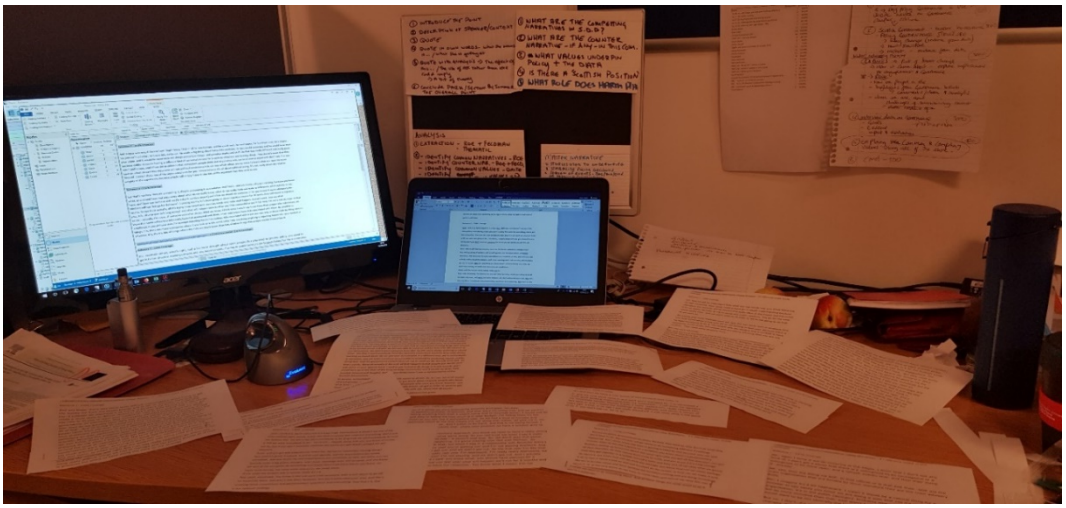
Methods of Accessing Data	Sources of Data	Types of Data Yielded
Participation	Institutional meetings Community groups SDPC – stakeholder group Informal conversations LLEEG MCRS	Interactions Stories/spoken language Narratives Non-verbal language Acts
Conversational interviewing and informal discussions	Multiple stakeholders	Stories/spoken language Nonverbal language Narratives Historical records, descriptions, events
Document analysis	Scottish Government reports Institutional reports Notes on meetings – both institutional and community based Surveys and reports Newspapers	Written language Historical records, descriptions, events Stories and narratives

Amount of time spent on each data collected	
Data	**Time**
12 interviews	11.5 hours of recording – 290 pages of transcript
12 SDPC sessions	36 hrs of participant observation
LLEEG events	3 events – 15 hours of participant observation – 5 hours of writing and dissemination of events
MCRS meetings	40+ hours of meetings, phone calls, emails and writing
Information meetings/conversations	Approximately 10 hours
Total hours	Approximatively 1275 hours
Auto-ethnographic note	Around 50 pages of reflective notes

Data Analysis

"Different data collection methods yield different information and they have to be interpreted differently. (Reissman 1993: 55).

My data analysis followed two distinct processes: grounded theory analysis, which led to the theoretical development, and narrative analysis. I conducted grounded theory analysis on my interview transcripts, which, combined with themes arising from my observation and document analysis led to the emergence of master narratives and the development of a critical drug theory. From this theoretical framework I chose one pillar – story-telling - and conducted narrative analysis on all my data which encompassed the master narratives identified in the initial coding.



Beginning the Process of Analysis and Writing. Photo by Anna Ross

In this section I shall set out how each of these processes came together in a flow consistent with an interpretive emergent and iterative research process

Using Grounded Theory Analysis

Grounded theory was first articulated in the ground-breaking book "*The Discovery of Grounded Theory"* (Glaser and Strauss, 1967). Previously there had not been a systematic and methodological approach to designing interpretive research studies (Wagenaar, 2015, ch.9). The emergence of grounded theory provided "*[s]ystematic inductive guidelines for collecting and analyzing data to build middle-ground theoretical frameworks that explain collected data*". (Charmaz, 2000, 509). While purists of grounded theory call for researchers to approach the data with an empty mind (Glaser and Strauss, 1967) more recent developments recognise the

importance of creating a dialogue between the researchers prior knowledge and the data (Charmaz, 2006; Wagenaar, 2015). As explored in chapter 2, understanding is not something which starts when we engage with our data, it includes a combination of the personal journeys we have been on and our specific academic and professional training. The challenge when conducting grounded theory is how to incorporate that knowledge while allowing for surprises to emerge from that data. This is where the initial steps in grounded theory analysis are important.

From the moment I entered into research mode I searched for common themes, picked up signals and undertones (and overtones), while at the same time being involved in the development of some of the narratives I studied. In keeping with a grounded approach there was a fluidity between the themes that I led, and themes that emerged from the data. This is known as pre-systemic coding (Charmaz, 2006, ch.3; Wagenaar, 2015, ch.9). Pre-systematic coding is an interesting time, the process of absorbing, recording, mentally filing and sorting. As I progressed through the observation, document analysis and initial interviews, I began to see themes emerge from the data which I noted and created memos from (Charmaz, 2006, ch.4).

The next stage in grounded theory analysis is close coding (Charmaz, 2006, ch.3; Wagenaar, 2015, ch.9) and I started by going through initial interviews transcripts. Other data I collected included field notes, reflections, and documents, which I analysed once I had established themes and ideas generated by the close coding of the interview data. These, combined with the notes and ideas I had gathered from pre-coding began to illuminate overarching themes, which led to two developments: the emergence of master and counter narratives, and the development of a critical drug theory (CDT).

I found the process of close coding difficult to begin with for two reasons. Firstly, I was hesitant about taking small chunks of data out of context and imposing my own interpretation on it. Secondly, as a result of pre-coding I had an idea of themes that were emerging from the data and I found it difficult to code without these themes directing my analysis. However,

> *"although grounded theory analysis is part of a larger, flexible, emergent, "improvisational" (Cerwonka & Malkki, 2007) process of inquiry and interpretation, in which research design, sampling, data collection and data analysis weave in and out of one another, qualitative data analysis represents the moment we test our insights against the world*" (Wagernaar, 2015, 259).

With this in mind I overcame my hesitation by keeping the codes closer to the text (Charmaz, 2006). For example, take the sentence:

> *"people talk about a chaotic lifestyle, I try to avoid…although I hear people talking about it I try to keep away from that because it is so close to talking about peoples lifestyle choice, and that's what people think we are dealing with."* (Senior Policy Officer).

I coded this as "*chaotic life is too close to calling it a lifestyle choic*e". This was further coded to represent "*stigma towards drug users"* and falls within the "*recovery master narrative"*. This is an active code which highlights how language can impact the way 'problematic drug users' are viewed: they choose to become problematic and therefore do not deserve social help in overcoming that 'problem'. Recovery is a way of redeeming yourself from this chaotic lifestyle choice and showing that you are a valuable member of society, and therefore deserving of help.

By coding line by line, and in some cases incident by incident, I was able to stick close to the data and build from the bottom up, as opposed the top down (Charmaz, 2006, ch.3). While I was close coding I kept memos of themes and ideas that emerged from the codes.

The Emergence of Critical Drug Theory

One of the main outputs of grounded theory is theoretical development (Glaser & Strauss, 1967; Charmaz, 2006; Wagenaar, 2015), yet there is a danger, highlighted by Wagenaar (2015), of hiding behind grand theories in order to prevent the messy work of getting to know your data. Initially I was hesitant about the development of CDT as I was unsure whether I had conducted enough analysis on my transcripts, until I realised that I had been conducting grounded theory from the start: my initial hunches, notes, memos, ideas and close coding were all legitimate steps in the theoretical development. I shall expand in detail on the development of CDT in chapter 8 but in brief it developed from a combination of interview data, field notes, observation, prior knowledge, and the term being presented to me as encapsulating what I was exploring. Diagram 4 below visualises the different analytical stages I progressed through to reach the analysis stage.

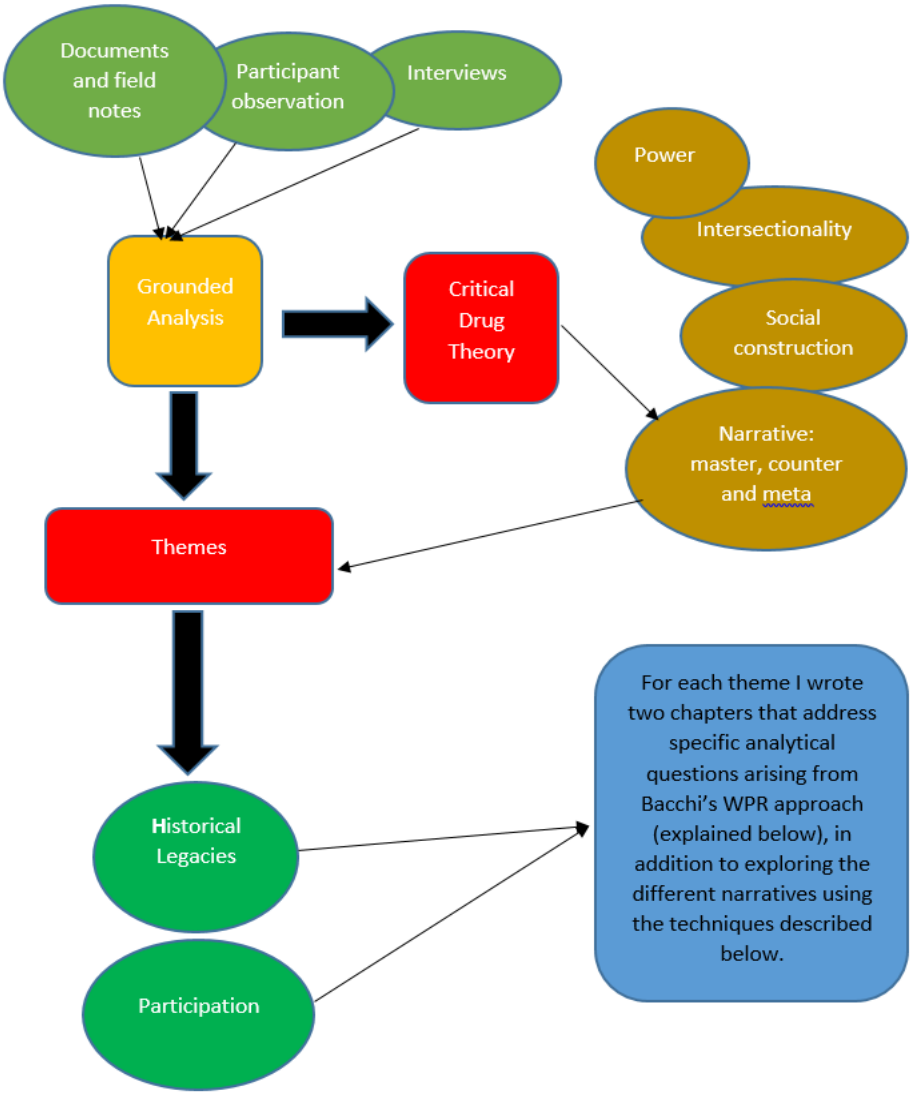


Diagram 4. Analytical Process. Design by Anna Ross

Conducting Narrative Analysis

Using narrative analysis in public policy can be overwhelming as there is such a variety of approaches to pick from. Mishler in his book, Models of Narrative Analysis, states that narrative is not really a distinct discipline but "*a problem-centred area of inquiry*" (1995 - quoted in Wagenaar, 2015, 216). This is why I initially struggled quite profoundly with trying to understand what approach I was using, and what approach fitted the research. In the end I realised that by approaching the whole project from a dialogical and interpretive mindset, I was able to use different narrative-based tools to analyse aspects of my data and present the narratives in multiple forms.

Narrative inquiry takes many forms, and for the purposes of my research I use it to scrutinise my interview transcripts and the broader reading material to determine (i) the personal narratives that stem from the individual, and (ii) the broader symbolic or master narratives that appear throughout the interviews, observation, documents and media. It is not about identifying an objective truth, but about understanding the meaning and experience of those involved.

My overarching analytical approach was the 'What's the Problem Represented to Be?' approach (WPR Approach) (Bacchi, 2009). By subjecting my data to each of the questions in the process set out by Bacchi, I teased out the individual and overarching narratives in my data. I also incorporated dialogical narrative analysis (DNA) into the process to take into account the dialogic nature of the research. For my chapter on historical legacies I used a form of practical storytelling (Forester, 1993; Wagenaar, 2015), in addition to DNA, to create a deeper understanding of the impact historical events have had on current drug policy narratives. In this section I set out why and how I used the different analytical strategies.

As stated, my analysis was not straightforward, and I subjected parts of my data to different analytical techniques before settling on a process. Having subjected my initial data to grounded theory analysis, and begun the process of developing CDT, which gave me a theoretical framework with which to identify my stories and narratives, I then applied two different analysis strategies; narrative and WPR.

Doing Dialogical Narrative Analysis

> "Dialogical narrative analysis (DNA) understands stories as artful representations of lives; stories reshape the past and imaginatively project the future. Stories revise people's sense of self, and they situate people in groups" *(Frank, 2015, p.2)*

The use of dialogical narrative analysis (DNA) is to explore what specific stories say about the storyteller, and whether these stories can be merged to find common and/or competing stories. Importantly it is an analysis tool that seeks to find the common stories told by multiple voices. It takes inspiration from Goffmans 'presentation of the self' (Frank, 2015) in the commitment that people tell stories about themselves and others that present a character, or ideal that they conform to.

However, there is a tension within DNA between dialogue and analysis. As Bakhtin (1984) writes: "*the author speaks not <u>about</u> a character, but <u>with</u> him*" (63, original emphasis). Bakhtin argues that "*the truth about a man in the mouths of others, not directed to him dialogically and therefore a <u>secondhand</u> truth, becomes a lie degrading and demeaning to him*" (59). This is exactly how I felt about the stories that my participants told me – we were in dialogue, and it initially felt degrading to subject the dialogue to analysis in which I decide what is *actually* being said. Naturally there are instances in the conversation where it is evident that biases, opinions and beliefs

shine through, but this is part of who my participant is, and all I can do is reflect on that and comment – as opposed to breaking the sentences up and creating meaning where there may have been none originally. This was a major hurdle for me to overcome, and in some ways I never have. I present the narratives and stories as truthfully as I can, but in the knowledge that it is my interpretation that guides the final presentation.

Dialogue is about conversations between multiple voices, and not just the two or more voices in the conversations – it is about seeing that stories evolve and are co-created (Frank, 2015, 3). Bakhtin described this process using two conceptual terms: "*polyphony"* – when individual stories merge together but are separate and aspects of their voices/stories form the plot, genre and overarching narrative; and "*heteroglossia"* – the overarching codes or narratives garnered from the many different sources (official documents, emotional expressions, common stories etc) which can be applied to guide the plot or genre. This research utilises both conceptual terms: by merging individual stories to find the overarching codes and narratives.

The biggest claim to authenticity and professional expertise is that the research has heard multiple stories and is therefore able to make the connections and overarching narratives which may allude individual stories. However, Frank in his research for The Wounded Storyteller, listened to his participants in order to bear witness to their stories. This was not to uncover some truth that the storyteller was unable to ascertain for themselves but: *"to witness, in the simplest sense of gathering voices to give them a more evocative force so that these storytellers could hear each other, and so that they could be heard collectively*" (Frank, 2015, 4).

This was also my intention. The puzzle which I had identified at the start of this research was "*why is it that despite the calls from so many around the world, and nationally, those who were perceived to be responsible (the policy actors) were still unable or unwilling to pursue more radical, but evidence based, reforms?*". I wanted to discover what collective goals and ideals those at this level had. As I collected the interviews and observations I began to realise that not only was it the marginalised voices of drug consumers that were being ignored, it was also the voices of those responsible for policy formation. I therefore sought to witness and collate the stories my participants told me so that I could record their anger, pain, joy and frustration, to ultimately create an idea of what is common amongst them, and what is different, or distinct.

> "Stories need humans in order to be told, and humans need stories in order to represent experiences that remain inchoate until they can be given narrative form" *(Frank 2010, 5).*

Another important element of DNA is there is no ending, no finale to the story (Frank, 2015). All stories evolve and move, and this is an important tension in DNA – that everything changes and there is no 'end'. Yet in a research report or thesis there needs to be a conclusion of sorts, so how do we get there? This can be dealt with in part by focussing on things that remain

constant throughout the research, for example the number of participants, the plot line, the genre etc. This allows conclusions to be drawn, yet the story goes on. It can also be dealt with by making it explicit that narrative analysis does not have a summary of findings – the dialogic world looks at exploring the narratives within the research in order to highlight the common or competing aspects of the story, rather than seeking claims of validity or generalisability: "*DNA rarely, if ever, prescribes responses. It seeks to show what is at stake in a story as a form of response*" (Frank, 2015, 6)

DNA sets the overall tone on how I approached the analytical process, but it is WPR analysis that provided the more advanced analytical tools that was needed for in-depth exploration.

Selecting Stories for Analysis

I set out critical drug theory (CDT) in the following chapter, but I used the principles of CDT and DNA to select stories based on my phronesis "*the practical wisdom gained through analytic experience*" (Frank, 2015, 11). When collecting data there will be stories which stand out and have multiple voices saying the same, or similar things, and the practiced wisdom of the researcher will enable these patterns to be identified. For example, during my interview process I began to see a pattern emerging, a story that needed to be told about the history of Scottish drug policy, and particular events throughout that period seemed to chime with many of my respondents. Phronesis also involves making these decisions based on value judgments and this relies on ethical grounding. Developing an ethical grounding required me to delve into the meaning of my research, as explored in chapter 1. It also involves the hermeneutic spiral - the constant re-evaluation of the story in light of new understandings. Therefore, narrative analysis is not about trying to present something that is the final outcome, it is about creating or crafting a story from the narratives that speak to you, and this will be dependent on each individual, and the original research questions. I therefore selected data (stories and narratives) that:

1. Answered one or more of the WPR questions, and;
2. Highlighted the master or counter narratives of drug policy in light of the themes generated by my grounded analysis and CDT, and;
3. Bore witness to the dialogue taking place between both the researcher and the participant, and the broader community.

Opening Up for Analysis – Bacchi's Problematisation Approach

> *"*the primary resources for telling a new story are the stories that are already circulating in the setting; again, recognizable character types, plot lines, genre choices and tropes" *(Frank, 2015, 13).*

In my research, the character of the 'problem drug user' is a constant, so is the intractable minister, or the caring practitioner. There are also plot lines that pop up repeatedly, making it possible to identify common themes and narratives. Initially I found the process of opening up the stories to deeper analysis, particularly my interview data, extremely difficult for the reasons outlined above. However, during the initial data collection process and coding I began to see the emergence of themes that would fit into the analytical framework outlined in Carol Bacchi's 'What's the Problem Represented to be' (WPR) (2009). I saw that by following her framework for analysing policy it was likely I would be able to build a case for a critical drug theory using tenets articulated in critical race theory (Delgado & Stafancic, 2012; Solorzano & Yosso, 2001). See diagram 5 below for a visual aid in how this framework was developed. Furthermore, as I started to write up the narratives I began to see how the questions set out by Bacchi could help structure the analysis in order to get beneath the narratives I had identified during the DNA process.

The WPR approach has been used to interrogate policy 'problems' by a range of researchers. For example Lancaster, Duke and Ritter (2015) use it to analyse the recovery discourse in Australia, Moore and Fraser (2013) use it to explore the production of the 'problem' of addiction in treatment services, and Lancaster and Ritter (2017) use it to examine the construction and representation of drugs in Australia (also c.f. Farrugia, Seear, & Fraser, 2017; Farrugia, 2016; Fraser & Moore, 2011; Lancaster, Seear, & Treloar, 2015; Lancaster, Seear, Treloar & Ritter, 2017; Lancaster, Treloar, & Ritter, 2017; Ma°nsson & Ekendahl, 2015; Manton & Moore, 2016; Seear & Fraser, 2014).

The approach itself is simple: using 6 questions the analyst works through the framework with aim of exploring what lies behind the 'problem' articulated by the policy. This is highly relevant to drug policy, particularly in Scotland where the explicit aim is to reduce the *harm* resulting from *problem* drug use (Scottish Government, 2015). By using these questions as a guide for the (i) coding and analysing the data, and (ii) structuring the thesis chapters, I was able to explore the underlying narratives within the communities I have studied, and construct the beginnings of a critical drug theory.

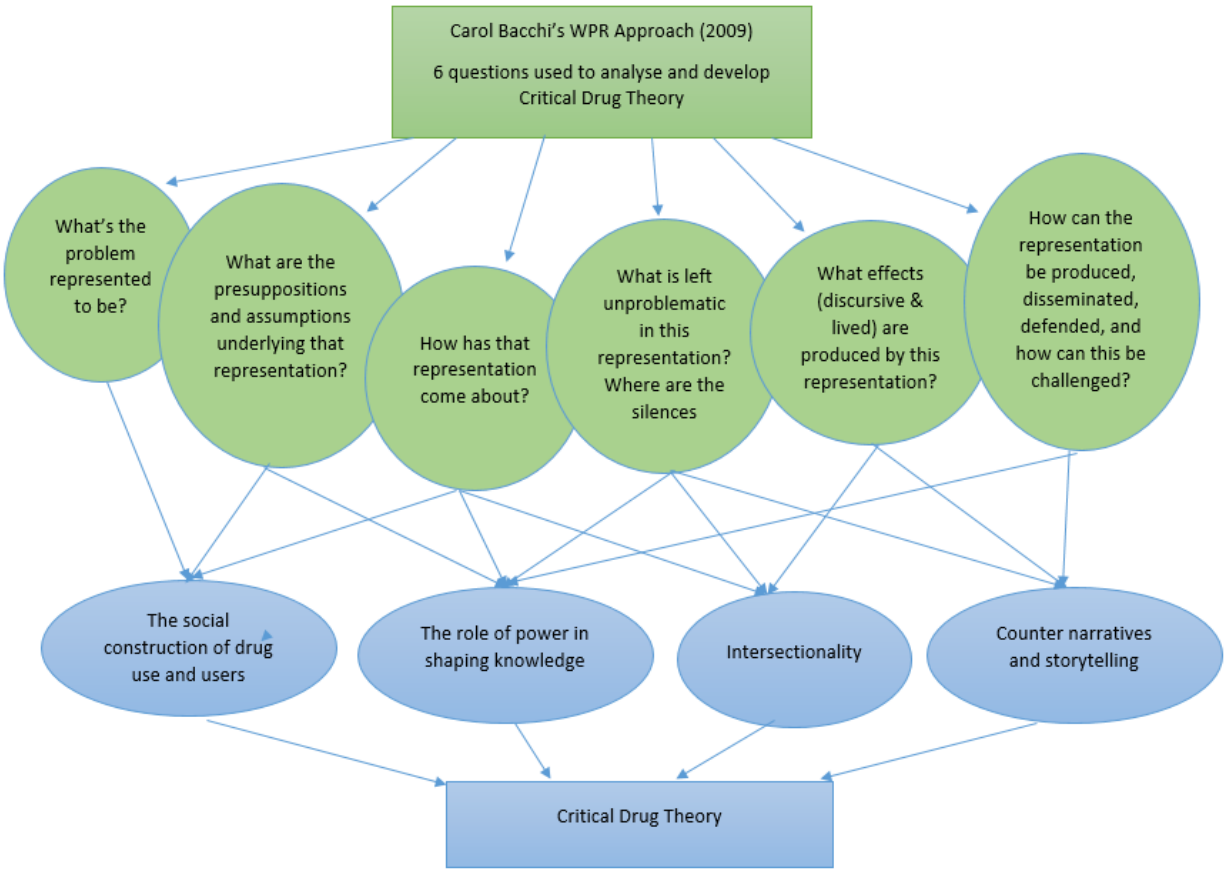


Diagram 5 – The Development of CDT. Design by Anna Ross

The questions, taken from Bacchi (2009) are:

1. What's the problem represented to be?
2. What are the presuppositions and assumptions underlying that representation?
3. How has that representation come about?
4. What is left unproblematic in this representation? Where are the silences?
5. What effects (discursive and lived) are produced by this representation?
6. How can the representation be produced, disseminated and defended, and how can this be challenged?

There is a final 7th question which challenges the researcher to apply the WPR approach to their own problem representation (Bacchi & Goodwin, 2016). In particular, researchers are encouraged to examine their own way of thinking and undertake to "*engage in self-problematization, seeking out possible forms of domination in their own proposals and problemitzations."* (40). I shall address these issues in the conclusion where I explore my role in the research in more depth.

The following chapters answer the 6 WPR questions in relation to drug policy in Scotland, and the representation of drug use and drug users. Below is a breakdown of which questions cover which chapters.

Historical Legacies – Chapters 4 to 6

WPR #1. What's the problem represented to be?
WPR #2. What presuppositions underlie this representation?
WPR #3. How has this representation come about?
WPR #4. What is left unproblematic, where are the silences?

This historical section explores the development of 'problem drug use' narratives in Scotland in 3 short chapters. It will show that historically policy has focussed on a certain demographic as a result of the increase in heroin use leading to the HIV crisis in the mid 1980s, and subsequent crisis points since. In doing so it highlights the silences within drug policy, namely the use of drugs for pleasure, medicine or therapeutic and spiritual value.

Participation in Drug Policy – Chapter 7

WPR #2. What presuppositions underlie this representation?
WPR #4. What is left unproblematic, where are the silences?
WPR #5. What effects - discursive etc are produced by this focus on 'problem drug use?'

The presupposition that underlies the representation is that drug use is harmful - therefore participation in policy is of stakeholders who have experienced this 'harm' and are seeking to reduce/eliminate it. This chapter will explore what is left unproblematic by showing that the focus on 'problem' drug use has resulted in a focus on certain kinds of drug consumption, and a policy agenda the match that - recovery. As a result, participation in policy is restricted to certain channels where the government feel they can be most effective- 'problem drug use' and users.

Developing a Critical Drug Theory - Chapters 8 and 9

WPR #6. How can the representation of the problem be disrupted/questioned/challenged/ replaced?

This contributions section consists of 2 chapters setting out the development of critical drug theory (CDT), showing how this can help to disrupt and question the representation of the problem, otherwise known as the master narrative. They do this by developing the concept of CDT,

and creating master, counter and meta narratives that highlight the different, and at times competing narratives that exist in Scottish drug policy.

Summary

In summary, much like the research design, the methodological process has been iterative and non-linear (abductive). I have used multiple methods for both data collection and data analysis, and as such have a broad understanding of the different ways in which social research is conducted. I have wondered whether this makes me a 'jack of all trades and a master of none', however the PhD is a place for learning the craft of research, and I feel it is my duty to be honest about the messy, difficult and at times confusing process this is.

The following chapters explore the field using both the WPR questions outlined above and the core research questions set out in chapter 2, namely:

- What are the master and counter narratives within Scottish drug policy communities?
- What are the challenges in engaging different epistemic communities in a participatory policy process?
- What is critical drug theory, and how can it help us understand drug policy formation in Scotland?

PART TWO

Historical Legacies

Introduction

The Development of Narratives in Scottish Drug Policy

This part of the thesis explores the development of 'problem' drug use narratives in Scotland by exploring the data using four WPR questions:

WPR #1. What's the problem represented to be?
WPR #2. What presuppositions underlie this representation?
WPR #3. How has this representation come about?
WPR #4. What is left unproblematic, where are the silences?

In doing so it will show that historically, policy has focused on a certain demographics as a result of the increase in heroin use leading to the HIV health emergency and subsequent crisis points. By exploring the history – the timeline of events – this section develops the understanding of the cultural and historical aspects that shaped the representation of the problem. Bacchi calls this an exercise in "Foucauldian Archaeology" (Bacchi, 2009, 5), and it is important in understanding the problematisation of a policy, and how the master narratives have been developed and sustained.

There are three time periods which arose from the data, in particular the interview data, as being important in distinguishing Scottish policy from UK policy, and helped to shape the drug policy framework we see today. This part of the thesis will take the reader through these time periods using the stories provided by my participants and supported by existing literature and documents. The bulk of the data is taken from four interview participants who were heavily involved in the drug policy community throughout the time periods. I have chosen their voices because they articulate the multiple stories and narratives I came across during my data collection, and are representative of the wider narratives present in the analysis of What's The Problem Is Represented To Be, what underlies it, and how it came about.

One note of caution, while I engage in analysis using the WPR approach, I do not subject my participants narratives to in-depth critique in this chapter for two reasons. Firstly, I am exploring this history through the lens of individual experience to help paint a deeper picture of the impact historical legacies have had on current policies and communities. Secondly, much of what my participants discuss is not disputed - there was a heroin epidemic and the McClelland Report made recommendations and the Scottish Advisory Council on the Misuse of Drugs was set up. It is the *experience* of those involved that I am interested in, and I take inspiration from writers such as Margaret Kovach who, in her PhD thesis and following book (Kovach, 2009), uses her interviews as conversations which are faithfully recreated in the thesis. I further use John Foresters technique

of creating 'windows' into the world I am exploring (Forester, website), moments in time that we can look at to better understand the world we are exploring. To this end I aim to develop a genealogy of Scottish drug policy that uses both primary and secondary data to tease out important historical representations of the drug 'problem' in Scotland. Critique of this representation will be developed in chapter 9, where I will tell stories based on the narratives discussed here, and provide more critical discussion on the issues arising from the narratives.[7]

This section is divided into three chapters with an introductory section. The introductory section will set out what the problem is represented to be in 2019, using government and other institutional documents that highlight how the 'drug problem' is represented, and answers WPR #1. The following three chapters will look at how this problem has come about, what presuppositions underlie it, and where the silences are (WPR #2, #3 & #4). I have chosen to start from this date for several reasons. Firstly, the time periods emerged from my data as significant in the development of Scottish drug policy. Until the late 1970's there was little in the way of official drug strategies specific to Scotland, or indeed the UK (ACMD, 1982; Dorn and South, 1987; the Senior Drug Advisor interview participant; Kidd, 2013). The 1971 Act had only recently been implemented, and the 'drug problem' was confined to a relatively small number of heroin users and cannabis smokers (Pearson, 1987; Dorn and South, 1987). Secondly, all my participants whose interview transcripts I have used became involved in the drugs field around the late 1970's and early 1980's. Therefore any genealogy using interview data can only start at the point the interview participants enter the scene. Finally, taking this into account it appears appropriate that the historical exploration begins at the time drug policy was beginning to become a 'policy problem' in both the UK and Scotland, according to both the primary and secondary data.

The Representation of the Problem

In December 2018, the Scottish Government's Substance Misuse Unit published their updated drug and alcohol strategy entitled '*Rights, Respect and Recovery'.* This strategy built on the cross-party drug strategy published 10 years earlier entitled *'The Road to Recovery* (2008)*'.* The 2008 document represented the problem in the following way:

> "Scotland has a long-standing and serious drug problem. An estimated 52,000 people are problem drug users; 40-60,000 children are affected by the drug problem of one or more parent; and there were 421 drug-related deaths in 2006. This has a significant impact on individuals, families and society – with an estimated economic and social cost of £2.6bn per annum" *(Road to Recovery, 2008, Executive Summary).*

[7] For a less narrative heavy account of Scottish drug policy during these time periods see Brian Kidd's Thesis *'Long term outcomes of methadone substitution therapy (OST-M) for opiate dependency*' (2013) which explores this topic in chapters 1 and 2.

It is clear from the 2008 strategy that the focus is very much on a particular construction of 'problem' drug use. But what is problem drug use? According to the Road to Recovery problem drug users are a "c*ategory of people who will be experiencing or causing social, psychological, physical, medical or legal problems because of their drug use. They are likely to be in touch with drug treatment services, although many will not*" (Scottish Government, 2008, 12). Furthermore, they are likely to be users of opiates and benzodiazepines as opposed to other non-opiate based drugs such as 3,4-Methylenedioxymethamphetamine **(**MDMA), amphetamine and psychedelics (Ibid, 1).

Following on from the 2008 strategy, the 2018 strategy takes the concept of 'problem drug users', and focuses on the underlying reasons why people may experience such problems:

> *"There is a growing awareness that those experiencing problematic alcohol and drug use are often carrying other burdens such as poverty, inequality and health challenges. This means they need to be supported rather than be stigmatised. Treatment services and organisations in Scotland are already jointly tackling the harms caused by alcohol and drugs and this new strategy reflects that"* (Scottish Government, 2018, Rights, Respect and Recovery, Executive Summary).

The institutional representation of the 'problem' therefore is for a section of the population who use drugs in such a way that it creates social, financial, physical and mental issues for them, and society, and that these people often have additional issues stemming from social determinants such as poverty, inequality and poor health. So how did this representation come about, and what presuppositions underlie it?

Chapter 4

The Heroin Years

Although distinct from the rest of the UK in many areas such as property law and most criminal law, in the 1980s Scotland did not have a devolved government and therefore responses to drug policy were set at a UK level, and Scottish specific responses were carried out by the Scottish Office. However, in the early 1980s Scotland started to witness a change in drug using habits, leading to an increase in heroin use, which in turn led to an increase in blood born viruses such as hepatitis B, C and HIV (McKeganey, et al, 2008; RSA, 2008; Scottish Affairs Committee, 1994; Scottish Affairs Committee, 2019; Pearson, 1987). This led to a response by Scottish practitioners which broke from the UK response, namely harm reduction measures such as needle exchanges and opioid replacement therapies (Scottish Home & Health Department, 1986, Stimson, 1987; MacGregor, 2017). The following stories explore the changing nature of drug use, and how people, and institutions in Scotland responded to this crisis.

We start off in the early 1980s with Interviewee #6. At the time, this interviewee was a member of the Strathclyde Police Drug Squad and witnessed the change from alcohol to heroin use among certain communities during this time:

> *"…I remember working on some secondment with the drugs squad in the mid-80s, and the concentration of heroin use was in Otago Street in the West End of Glasgow. Where there used to be flats and they were in rows above each other, that's where the heroin issue was. And your heroin user was your long-haired hippie type, and Neil out of the Young Ones*[8] *you know, 'here come the pigs', you know the profile of a heroin user that is quite different. But then we started seeing people who are well known criminals now dipping their toe into the water and stolen cars became serious jail time so they went into drug dealing, and then we started seeing the emergence of heroin in the schemes (social housing) because people were selling it and making money*" (Retired Police Officer).

What we see here is the experience of a cultural shift in drug taking from one of low level 'bohemian' use to more large scale commercial use. From this extract it appears that the car industry, by improving the anti-theft devices on cars, diverted the criminal activity away from car thefts towards a more profitable criminal venture in the drugs trade. So, what happened that made heroin such a profitable venture? It is evident that the changing nature of crime and responses to crime were in part responsible for the increase in drug dealing, yet in order for the drug dealing to be profitable there needs to be a market, and something happened in the early to mid-1980s that created the conditions for large scale drug use.

[8] A British comedy show during the 1980s.

The following extract is from interviewee #5, Scottish Justice Minister from 2009-2014, and a criminal defence lawyer during the early 1980s:

> *"Well I think it was mass unemployment. Mass unemployment, hopelessness, kids were hanging around, there was no jobs you know. I mean okay you could say a lot of the ones maybe taking drugs were working because they had money, but it was the unemployment in the main. It just… it collapsed a whole society… the decent respectable working class just imploded you know, dad was depressed, dad was on the drink you know, and it was hopelessness, there was no future, you weren't gonnae get a job, so who cares! I suppose it's that replication, I mean I always remember when I was Justice Secretary that drugs offences in Shetland were perceived as different because they're actually working people. And it was the fishing. I mean it was 'don't tell me it will kill me because I'm out there and I could get swept away', and actually the heroin problem in Shetland wasn't coming from marginalized housing schemes, it was coming from people who were actually doing remarkably well, making money, I mean the trawlers (fishermen). But that was a culture there. Other than that, in central Scotland it was poverty and despair. This is the whole implosion of society! Your society in the housing schemes just began to disintegrate. You know the old men who would have been in charge were denigrated because they were shuffling round unemployed, so everything just tumbled down into that. Then of course where there's a market criminal gangs came in and that's why the Arthur Thompson's (notorious Scottish crime boss), who initially disdained drugs and would have nothing to do with it, all of a sudden moved in. So for lawyers all of a sudden boof…off it took"* (Scottish Minister #1).

This experience, and opinion on what was causing the shift towards greater drug use, and in particular dependent heroin use, is supported by a large body of research that links neo-liberal economic policies of the 1980s to long term poverty and high mortality rates in Scotland (MacGregor, 2017; Galea et al, 2005; McCartney et al, 2012; Scott-Samuel et al, 2014; Collins et al, 2011; Dorn and South, 1987; Minton et al, 2017; Scottish Affairs Committee, 2019; Parkinson et al 2016). In particular, recent research has shown that the impact of these policies on vulnerable men such as those transitioning from teenage to adulthood, and those who are unemployed or from deprived environments, has resulted in a steady increase in drug related deaths (Parkinson et al, 2017; Minton et al, 2017). This research built on previous papers exploring Scotland's excessive mortality rates compared to the rest of the UK and Western Europe (Parkinson et al, 2016; McCartney et al, 2011) and was hailed by many in the field as confirmation of the impact Conservative policies have had on the most vulnerable populations. While the policies of de-industrialization impacted the whole of the UK, Scotland was disproportionately affected as a result of having a large industry-based economy. The closure of multiple industries, particularly in the west coast and upper east coast of Scotland,

resulted in mass job losses, and there were no new jobs created. This led to a sense of hopelessness and despair amongst the affected communities.

In 2019, while writing my thesis, I worked as a Special Adviser to the Scottish Affairs Select Committee for their inquiry into 'problem drug use in Scotland'. In this role I helped steer the tone of the committee inquiry, selected witnesses for evidence, and helped write the report. Many of the topics covered in this thesis were evidenced in the report, although I have not included much as it took place after the data collection period. However, in relation to the impact of de-industrialisation on Scottish communities, one of our witnesses had this to say:

> *"The area that I was living in was being pulled down. It was an area of urban deprivation. There was high unemployment and crime. It seemed that nobody was working. Bear in mind that I grew up during the miners' strike, you know. It was probably a sense of hopelessness throughout the area. There was no investment in the area. There was no community centre as such. For me looking back, it was a sense of no hope and no sense of purpose […] Just that: feeling heartbreak, feeling "what's the point?" and I coped with that by using substances"* (witness, Scottish Affairs Select Committee, 2019, p.11).

The following interview participant, a support worker working in a deprived area of Glasgow at the time, recalls:

> *"My own personal simple view would be is in terms of the market. The market had reached Glasgow from the South, whatever way, and probably it could be a mixture of the experience young people had of alcohol problems, you know maybe made them look elsewhere, and then the particular, you know, combined with the view it was subversive, it was part of the criminal infrastructure, you know. And I think under Thatcher there was a growing dissent and division in the country and em…I think people found it helped kill pain, kill worry, that's probably a lot to do with it, and it was also a cultural thing that people shared* (Longstanding Government Advisor).

However, while there is no doubt these policies had an impact, as demonstrated by research and my own participants' experience, the link to current drug related deaths may suit the narrative promoted by the Scottish Government. This narrative is that the rise in drug related deaths is a result of an aging cohort who became addicted to heroin during the 1980s stemming from UK Conservative policies at the time. It is this presupposition that underlies much of the Scottish government responses to drug use, and shapes the narrative of how Scotland developed such a large drug problem. Focusing on policies from the past diverts attention away from the impact current polices, both from the UK and Scottish Government, are having on 'problematic drug users' such as reduction in drug treatment budgets and failure to implement evidenced harm reduction measures (McAuley et al, 2017). Nevertheless, there is strong evidence to support the claim that the shift in drug using trends during

the 1980s was predominantly a result of the economic policies, by governments and companies alike (c.f. MacGregor, 2017). This changing culture is explored below by a participant who experienced it. Here he talks about his experience of purchasing drugs during this changing culture:

> *Senior Policy Officer: "[A]nd sociologically this as an interesting time, I mean it would have been 1982/3/4, or 3/4/5 maybe. So, in the West End of Glasgow in those days the sort of middle class drug users, we used to buy cannabis from old bikers, hippies, guys what were around the university, or that sort of milieu, they wouldn't have been matriculated students necessarily, but they were around that scene. And, one summer, I would say it was the summer of 82/83, in the pubs in the West End of Glasgow, all of a sudden these working class guys started selling drugs, and cannabis and amphetamines. And they sold it in a completely different way, so they were much more reliable right, you didn't have to hang about waiting for a man kind of thing, hanging about waiting for some older greasy biker, muck you about in a kind of patronizing way. It was much more open, I mean this guy was about the same age as you, slighter older, he was heavy to hang about with, in fact you didn't hang about with him, you went in, you were a customer, and you walked back out. And it was much more open dealing, so I can remember going into a pub and there was a guy sitting there with lots of cannabis sitting there on a table, or the bar, he was just dealing like he's opened a shop. And whether that was including the management, or the management had been…were scared to do anything about it I dunno, but it was a lot more open dealing.*
>
> *Interviewer: Would you link that to de-industrialization and lack of opportunity? The beginning the of the drug economy?*
>
> *Senior Policy Officer: And it was that. Some of those guys who were um, culturally they looked like football casuals, you know, guys in their late teens, they had a sort of way of dressing which was meant to be kind of sharp if you like, and they were kind of in their own way kind of clean cut guys, but they had a heaviness about them, and some of those guys developed serious substance use problems, some of them will have moved on in life, and I suspect some of them, the guys I knew at that time, will be Mr Big from some notorious family in a scheme in Glasgow. But that was the very beginning of that and you saw that supply chain change entirely and become much more organized, and people had pitches and all that, which you know…people will have had them in the past, but it was a very different world, and I'm not so sure that we've done anything to fully catch up with what's going on there at all.*

Although the interviewee does not directly answer my question on whether the increase and change in drug use can be linked to de-industrialisation, he tells us an important story about the professionalization of drug dealing, and ergo its' potential to capitalise on the increase in demand. Sociologically this time period is indeed very interesting as we witness a shift from the early concepts of drug users being part of defined sub groups such as bikers (Young, 1971), musicians (Becker, 1963)

or hippies, to more ubiquitous, commercially driven drug use and dealing. Interestingly, the fact that this new breed of drug dealer stems from the working classes can be linked to change in gang culture in the 1980's, from theft to drug dealing. This move created opportunities for hierarchical structures that were being lost as a result of the disintegration of the traditional working class communities. The influx of heroin into these communities opened up previously unavailable opportunities for this kind of gang culture. It also caused widespread concern and challenges for practitioners in the field and significantly changed the way in which institutions reacted to drug use (Buchanan & Wyke, 1987; Dorn & South, 1987; MacGregor, 2017), as a participant working as a GP at the time recalls:

> *"[t]his is '79-'80. And just out of nowhere, extraordinary, with all sorts of stories you know, like most of them didn't know what heroin was. We would ask them are you using heroin, and they would say no I'm using smack, and you'd say that's heroin. They'd say no it's smack, and you'd say well what's in it, and you know… people were totally uninformed"* (Senior Drug Advisor).

There was a lack of knowledge surrounding heroin and its potential for physical dependency at this time, by consumers and the medical profession. As a result, the increase in heroin use without the harm reduction measures we are familiar with today, such as needle exchanges and opioid replacement therapies, combined with a tepid institutional response arguably exacerbated the spread of HIV and other blood born viruses, and provided the presuppositions for the narrative of problem drug use and drug harm we see today. This Senior Drug Advisor was a GP at the time and helped to identify HIV in injecting drug users. He said:

> *"You know the electorate were really taken for a ride and there was a lot of damage done I think especially in those poor communities, and there was no interest, I mean drug clinics were closing down. You know the drug clinics were set up in 1967 across the country, 200 drug clinics across the UK, which worked actually quite well to start with. But then they stopped working because money ran out, people developed this notion that recovery was all about abstinence. I mean the new national guidelines in 1982, said give people methadone for two weeks and then stop because they're better. The Advisory Council on the Misuse of Drugs, their treatment and rehabilitation document in 1980, 81/82 maybe (ACMD, 1982), said there was no medical role in treating, it was all about social services, and recovery, the same as the agenda now. But within a very short period of time we had an epidemic of hepatitis, and we had people coming in with jaundice, and we started this study just taking blood from patients with jaundice and testing them for hepatitis, hep B, there is no test for hep C at that time, but we know now there was hep C as well, and we know now that HIV was going through that group at the same time... But nobody knew they had HIV or hep C, and it wasn't until 1985 that we got a test for HIV we are able to identify and show that there had been an epidemic in Edinburgh."*

In 1985 the narrator and his colleagues discovered that many of their injecting drug users were also carriers of the human immunodeficiency virus (HIV). This created a national furore and paved the way for harm reduction measures that had previously been dismissed. The Senior Drug Advisor again:

> *"well we published in 86*[9] *it was published, but the test became available in September '85 and Tom Peter and a few other colleagues in Edinburgh did some testing of people who they thought were drug users in casualty in Edinburgh, found some positive HIV tests and published that in the Lancet and everybody was shocked and horrified. But we had this database, we had a database of about 200 patients. We had stored samples in the lab which were taken for the hep B patients so we went to test all the samples, and we found out that 51% of them were positive. And in fact a lot of them were old samples so possibly even as much is 60% or 65% of them were positive for HIV. That was a game changer, I mean that was published in the BMJ, and over the next 12 months we had approximately 50 film crews, and television companies, and I thought the BBC only had one film crew but you know the hundreds of people that came to the door of Muirehouse*[10] *surgery, and phoned me up wanted an interview, wanted to meet drug users wanted to talk about HIV, wanted to explore all the issues. Everybody. And of course policy people, government people, from Westminster because you know drugs is still a reserved power, and then there is no devolved Scottish Government, so most of the interest was from Westminster. So there was a huge amount of interest, and on the back of that there was research money, you know where you get interest like that you get research money."*

As a result of the publication, Scotland became the focus of attention. As the narrator points out Scotland did not have its own department on drug policy, however, despite this it implemented measures to counter the harm stemming from injecting drug use by introducing needle exchange and methadone programmes, backed by the Scottish Home and Health Department. Interviewee #10 continued:

> *"I mean Scotland was ahead of England because of our problem, and Scotland had this committee, MacLelland Committee, Brian McClelland was the Director of the Transfusion Service…So Brian McClelland convened this committee and we all sat and chatted for a few weeks and decided that we had to give people methadone, and give them needles and syringes, and that of course was revolutionary, I mean it wasn't really - as we been doing it already- but it allowed us to do it without any criticism. And all we were doing was copying Amsterdam, I mean Amsterdam the previous year had given out 500 sets of syringes without any reports of any bad things happening so really we were copying them, but we were the first in Britain, and the McClelland Committee was the first committee that*

[9] Robertson et al, 1986.
[10] An area of Edinburgh, Scotland.

actually sanctioned distribution of needles and syringes[11]*. The Dutch had sort of done it as part of the Junkie Bond: a group of users who set up their own group and distributed needles and syringes and they got criticism, but the Dutch Government couldn't decide what to do, so didn't prosecute them and didn't pursue them. The Junkie Bond became quite famous across Europe, and everybody suddenly thought 'you know that they got something here, you know they are actually doing some prevention'. So we were copying them and we did needles and syringes, and the Lord Advocate eventually said we could do it. And then England copied on really off that, the Advisory Council really and the Home Office Committee did a report the year after*[12]*, which more or less at the same as the McClelland report, except with more detail and more national coverage. But Scotland was the first."*

The importance of this process was that Scotland began to focus on harms stemming from drug use as a health problem, and power to do this was given by the Lord Advocate of Scotland. The Lord Advocate of Scotland is a constitutional post and provides judgments on whether an action contravenes the constitutional arrangements between the UK Government and Scotland. At the time there was no devolved Scottish parliament, but aspects of the law had always been separate, and the role of the Lord Advocate was to mediate these aspects. As can be seen here, the Lord Advocate made a bold decision in the face of a national crisis to allow the provision of drug using paraphernalia (specifically prohibited under the Misuse of Drugs Act 1971), although he was backed by the Home Office at the time:

"[B]ut when HIV came along they [the Home Office] didn't know what to do, they sort of said well this is actually medical stuff, it's nothing to do with us, it is best placed as medical. And they were right, they're right" (Senior Drug Advisor).

This is contrasted with a recent Lord Advocates ruling on drug consumption rooms: a proposal put forward in 2018 to provide harm reduction for street injecting drug users, in the face of an increase in HIV infection for the first time in 20 years. In the recent ruling, the Lord Advocate refused to comment on the legality of setting them up, citing it as a public health issue, and therefore not suitable for a Lords Advocates reference (SDF, 2017). As can be seen, this is not entirely accurate, and it is interesting that over 30 years later Scotland appears to be in a similar position regarding responses to drug related harm. I shall explore this in more detail below.

The Muirhouse practice in which interviewee #10 was working during this time was subject to intense scrutiny and a large influx of injecting drug users. There was great debate among practitioners about how to respond to the epidemic unfolding which focused on the role of maintenance (harm reduction) versus abstinence (Buchanan & Wyke, 1987), and this was compounded by the intense fear felt by those working directly with injecting drug users:

[11] Scottish Home and Health Department, 1986.
[12] Advisory Council on the Misuse of Drugs (ACMD), 1988.

"And the police were… it's hard to remember how worried everybody was, there was a real fear about HIV, I mean a real fear. You know people wouldn't sit next to somebody in the bus because they thought they might have HIV, you know one of our drug users spat at somebody in Jenners department store, and was taken to court for attempted murder, you know because…you know there are all sorts of cases like that. And people were very worried about contamination in the blood suddenly became poisonous, you know whereas you know we used to take blood samples and slosh blood around into different tubes, and you get blood on your hands, you know you put into a tube that was bloodstained and then put into a tray in the lab, I would come pick it up, the blood sample would get cracked and then the blood on the tray, and it was just quite different. And all of a sudden nobody would take the blood samples from drug users, you know nobody wants to touch them, for fear. You know people didn't know to be fair.

And then the test came in. So a real turning point study was Gerald Friedland who is one of the physicians in the Bronx and he tested everybody he could get hold of who lived with somebody who is HIV-positive and found out that none of them are positive, except people who had had sex with them or were sharing needles[13]*. And he concluded from this, and it wasn't a terribly big paper, it wasn't terribly scientific, but it was a breath of fresh air, it was just a huge sigh of relief from the profession saying actually maybe it isn't that infectious. So it's blood to blood, you can spread it sexually you can spread it by needles, you can spread it by blood transfusion, and very rarely you could get it by needlestick or contamination. But otherwise you're not going to get it, and all of a sudden it switched of the huge anxiety amongst the profession, and to a certain extent amongst the public as it filtered through"* (Senior Drug Advisor).

The point of highlighting this fear-based narrative is that it is this fear - of contamination and more broadly the drug users themselves - that has been sustained throughout the decades. Despite it being known that HIV can only be spread through blood to blood, the image of the sick, dependent and dirty drug user has stuck in societies imagination. As one participant said of the time:

"When I worked in the Citizens Advice Bureau there the guy that I went out with, he had whole groups of friends that had died in shooting galleries and you know, he wasn't drug user himself, but he knew whole families, 3 sons had died of heroin related…so…yeah, I suppose growing up in Edinburgh in the 80s you had a very strong view of heroin, so I think that's quite interesting, the extent to which that experience probably – not necessarily personally but I see that played out through the Road to Recovery" (Senior Civil Servant).

This image underlies much of the current representation of the problem: that drug users suffer harm (and death) as a result of their drug use, and therefore strategies to address this harm are the most important focus. This is reflected in a broader public narrative about the harm of drugs, and the

[13] Friedland et al, 1986.

'problem' of drug users. There is a view amongst many politicians, and policy makers, that 'the public' are a homogenous group 'out there' that supports punitive approaches to drug policy because of this harm narrative. It is felt that any moves to disrupt this focus would result in election defeat and uproar from this 'public'. As one participant, who was in government during the late 1990s, said: "*I mean too often politics ends up in that place where you do things that are described as tough, and maybe look tough, but if they're ineffective then so what?"* (Ex Scottish Minister #1). This constant need to look tough and alleviate 'public' concern has been a barrier to effective reform. Furthermore, the idea that the public consist of one group is misguided. Drug users are 'the public', drug users families are 'the public' policy makers are 'the public'. This othering of stakeholders away from the 'general public' is one of the things that continues the narrative of harm.

This narrative was in the process of being developed in the 1980s, and as interviewee #4 points out, was reflected some 20 years later in the Scottish drug strategy. Furthermore, heroin users were associated with crime, another deviant activity that influenced the representation of the drug user:

> *"[w]ell the 80s was HIV and all these things you know. Theft went through the roof, the number of clients you had that were just feeding a drug habit you know. And it escalated you know. It would start off just shop lifting and then they'd end up doing house robberies, you know house robberies with people in the house"* (Ex Scottish Minister #1).

This quote illustrates the increase in criminal activity that surrounded dependent heroin use in the mid 1980's, and as a result there began an association of drug use with criminal activities such as house robbery. This, combined with the kinds of communities many heroin users were, and still come from (working class or lower socioeconomic communities) (Pearson, 1987; Milton, 2017), meant that despite there being a national crisis, the amount of money needed to invest properly in these services was not forthcoming.

> *"You know people always say well it must've been great and things were easy, and the health service, and there was loads of money, but there's never been loads of money, and there's never been a time when people weren't stressed and vexed by not having enough resources. But mental health has always been bad, it's always been the bottom of the pile, and drug use of course is the bottom of the bottom of the pile, you know - a lot of stigma a lot of prejudice, a lot of poor press coverage, you know which we did get. But the press was not quite so intrusive, so vicious. I mean I'm glad that they weren't, you know we did get… I mean the Home Office used come round, you know the Drug Inspectorate, and we got to know them quite well, and they came round, and they gave us rather sort of cryptic warnings, you know about 'you better be careful we are watching you and we are recording your every prescription'. And we so said okay so is that a good or a bad thing [laughter]"* (Senior Drug Advisor).

The impact of the heroin/HIV epidemic was seismic. In 10 years Scotland went from having virtually no institutionally agreed responses to drug harm, to a world leading harm reduction program in the form of needle exchanges, opioid replacement therapies and ultimately a strategy specifically for Scotland (Scottish Affairs Committee, 1994). This period created the conditions for the representation of drug use as a problem, with unacceptable levels of harm stemming from use. It dominated the narratives of several key participants in my research and had a lasting impact on the way Scotland responded to drug use. Nevertheless, there were constant challenges in implementing these initiatives and the intervening years between 1990 and 2008 saw a mix of policies and responses.

Summary

This chapter sought explore 4 of the WPR questions using the historical legacies, and told through the experience of key actors. What we can see here is that the representation of the problem of drugs (as set out in the introduction to this set of chapters) began to develop in more depth during the 1980's. The representation came about as a result of the focus on injecting heroin use and resulting HIV/AIDS and blood borne viruses transmission associated with injecting drug use (WPR#3). The underlying presupposition developed at this time was that drug use was harmful, bad and resulted in death or severe health consequences for both the individual and society at large (WPR#2). As a result the problem of drugs started to become represented by poverty stricken injecting drug users (the trainspotting generation – WPR#1). Yet missing from all of this is the other forms of drug use, the cannabis smoker, the psychedelic traveller, the amphetamine associated with the punk scene, and the MDMA user just starting to get going in the UK (WPR#4). The next chapter will start to address this silence using my own experience and auto-ethnography.

Chapter 5

The Intervening Years: Developing the Narrative of Harm, Silencing the Narrative of Pleasure

This chapter charts the intervening years between the end of the 'heroin epidemic' and the implementation of the Road to Recovery (2008). I was a child during the 1980s, so the stories collected from that time are from my interviewees and literature. However, from 1994 onwards I can start to input my own auto-ethnographic/reflective accounts of drug use and drug policy, in particular to highlight where the silences are in the developing institutional narrative response to drug use. This speaks to #4 (where are the silences?) and #5 (what are the effects?) of the WPR approach, as well as developing groundwork for critical drug theory by using personal narrative to highlight marginalisation. In this chapter I do this by using diary entries and reflection on those years, combined with interview and other data relevant to that time.

The years between the heroin epidemic of the 1980s and the implementation of the Road to Recovery in 2008 saw a raft of changes in Scottish drug policy, not least the impact of the devolved Scottish Parliament in 1998. Overall, in the policy world, there was a further shift towards treating problematic drug use as a health issue over a criminal issue (see the list of reports in appendix) and from 2001 there was a strong focus on 'recovery' and treatment as a process for addressing drug problems (Kidd, 2013, ch.2). However, until 1998 all drugs policy rested with the UK Justice Department, and enforcement was a major part of the policy response. Following devolution in 1998, public health responses to drug use were devolved to the Scottish Parliament, and enforcement of criminal sanctions were carried out by the Scottish police and courts. Legislative changes however continued (and continue) to reside with the UK Justice Department.

Because of this focus on problem drug use, other forms of drug use, and drugs, were largely ignored in official policy responses. Yet it is during this period that Scotland saw a huge increase in the use of psychostimulant drugs such as MDMA, amphetamine and cannabis, something the Retired Police Officer witnessed during his time in the drug squad:

> *"I saw the ecstasy market come from absolutely nothing, and it was all about the club scene. I had one of the biggest recoveries in Scotland which was 111 MDMA tablets, that would have been around 1990, the biggest at that time, when I first went to the Drugs Squad, and it (the MDMA) was destined for the hanger 13 scenes down in Ayr (West Coast of Scotland). There was a huge rave scene down in Ayr, and that's where they all went. And that's exactly what they were all doing. They were sourcing eccies (MDMA), taking them down there, punting them and that was like your night out, your drugs, and a bit of business*

as a side line. I was in the drugs squad proper until 1994, and I remember latterly 600,000 ecstasy tablets in a concealment coming in from Belgium and I took them out and they were concealed in a van."

This participant is talking about the burgeoning rave culture in the early 1990's, where hundreds of young people would converge in old warehouses and airfields in the country to listen to loud techno/dance music, and consume ecstasy. What he is describing here is the increase in the amount of ecstasy in four years: going from just a couple of hundred confiscated during a weekend, to hundreds of thousands of tablets being shipped in for consumption. It was during this time that I got involved in the rave scene as a result of hanging out with punks who were also into techno/dance music. In the following excerpt I reflect on the first time I took an ecstasy tablet:

"I took ecstasy on New Year 1994 when I had just turned 16. We had found an afterparty in the New town (of Edinburgh), an old townhouse rigged with stolen electricity and different dance rooms on all floors, it was mental. I had a gram of speed (amphetamine) in my pocket and had taken some already that night but when I looked for it at the party it must have fallen out my pocket as it was not there. I was with school friends, but funnily enough the folk I was with were not into taking drugs, except one. Anyway, we are at this party and the guy who had taken us there who was lovely said he could get me some pills, seeing as I had lost my speed. So, he got us a pill, they were California Sunrises I think, and me and a friend shared it. Everyone else went home and me and her stayed. I remember sitting in the chill out room having amazing conversations with people, feeling light and warm and fluffy and in love with my new experience. At the time I didn't think I was feeling anything, it felt natural, but just like the speed experience I remember chatting to a woman telling her it was my first time but it didn't seem to be working and she just smiled at me. Finally we made our way home and crawled into my single camp bed at 7am, both of us feeling light and fluffy and bonded. My ecstasy experience was the beginning of a very nice relationship with that drug, I had some very good, life affirming times over the next decade."

Photo 5: Me at the age of 20–some after party. Photo credit unknown, circa 1999

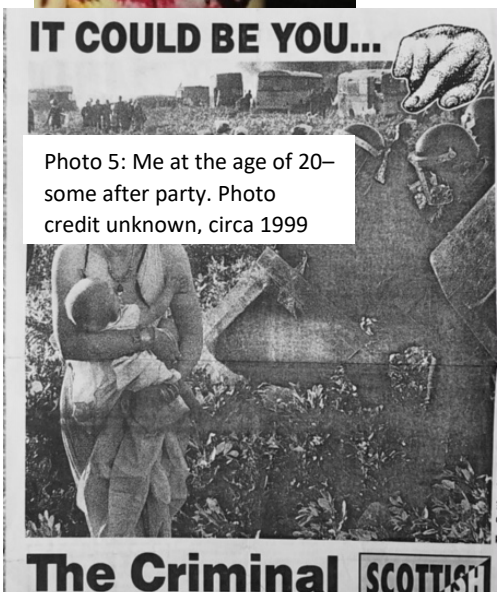


Photo 6: Scanned poster I kept from demonstrations. Poster credit unknown. Circa 1996

Around this time there was a brief institutional focus on this kind of drug use, in response to an increase in illegal raves taking place in warehouses and empty fields across the country. The UK Government's response was to deter such activity by passing the Criminal Justice and Public Order Act 1994. The Act was wide ranging, and targeted the traveller communities in particular. But it was Part V that those of us involved in the

rave scene at the time saw as an act of state repression. It was Section 63(1)(b) that stuck out and made it illegal to play certain kinds of music: "*music includes sounds wholly or predominantly characterised by the emission of a succession of repetitive beats*." The passing of this Act resulted in a massive crack down on warehouse parties and illegal raves. My friends and I attended demonstrations and continued to go to illegal raves, but the enforcement became heavier, and gradually the music moved to licensed clubs and festival venues.

Another of my participants, who remains anonymous for this extract, talks about their experience during this time:

> *"Well yeah, I think in the sense, as I say, it was all kind of influenced around music so like when I was late to mid teens it was kind of indy and stuff like that, and that kind of influenced all the other activities, so fashion, drugs, gigs and that sort of stuff, and then yeah, then I started going raving and that all changed the scene. And once we were driving, we used to go to raves out in the countryside and then like drive home (tentative laughter)… [A]nd the all night clubs, they were wicked... Yeah it was like a kind of group mentality. It was all fun and everyone looked out for each other… and I think that thing of people looking out for each other when you're raving and stuff and making sure everyone's alright was probably good for me... So yeah, pretty positive."*

Thatcher's War on Acid House. Source: Vice.com[14]

[14] https://www.vice.com/en_uk/article/8gvp5x/margaret-thatcher-war-on-rave-acid-house-boys-own

What we are seeing here is a window into a drug scene that was characterised by people experiencing pleasure as a result of their drug use. This is in contrast to the narrative of drug harm that was developing as a result of the heroin/HIV epidemic. The thing I find most fascinating when I look back at those times is that the people I raved with were from all walks of life, and many of them came from communities that were in the grips of heroin use. We connected through our use of illegal drugs, and the music that came with it, dancing for six hours till our bodies were soaked in sweat, breaking only for water and animated chats with a new best friend when you went to the toilet. After the clubs we would return to an after-party and there the conversations and dancing continued. It is during this time that my deviant identity was developed.

Picture taken 1999 at an afterparty. The police had been called because of a noise complaint, and were asking us to turn it down. The routine was they would wait around until we had turned it down, and some folk had left. Often this was a good excuse to get rid of anyone who was being a pain in the arse or causing trouble. I was into photography and asked everyone in the picture if it was okay to photograph, although I am not sure how much consent my friend was capable of giving! She has since 'soberly' consented. I thought it was an interesting exchange, and showed the tolerance of the police towards the ravers during this time. We were not travellers, or having a free party, just a large party in a small flat in a housing scheme, with a massive sound system after a club.

I was 19 at this time, and my life consisted of working in a late night café near Edinburgh University called Negociants, and clubbing/partying.

As well as the enforcement focus on ecstasy, in 1996 a retired policeman's daughter, Leah Betts, died from drinking too much water while high on ecstasy (The Independent, 1996). The ensuing moral panic surrounding her death, fuelled by her father's grief, resulted in ecstasy and the associated clubbing being viewed as harmful. It is around this time that Crew 2000 were working to respond to the increase of people using psychoactive drugs, and the differences in strength and purity.

As a clubber using a considerable amount of ecstasy at the time, I noticed the change in quality. Until 1998 my personal experience had been that although different brands had different qualities, generally speaking you knew what you were getting. California Sunrises were extremely lovey, rhubarb and custard were red and yellow, and more speedy, Mitsubishis were full of ketamine, and

signalled the death of clubbing to me. They came in around 1999/2000, along with GHB (gamma-hydroxybutyrate) and ketamine powder, and killed the love vibe.

Shaken or stirred. Original poster from Crew 2000. The message is harm reduction – don't mix your drugs, and take small amounts in increments. Photo by Vicki Craic of Crew 2000

The other thing that killed the vibe was alcopops. Indeed, during an interesting conversation with the Senior Drug Advisor we discussed alcopops in the clubbing scene. This extract also shows

how I developed relationships with my interviewees, by being completely honest about my experience, sharing my stories, and encouraging them to share their own.

> *Interviewer: "I was a raver when alcohol pops came in and they were the death of the rave scene. You know we used to go clubbing and take maybe one, one and a half ecstasy tablets, dance for six hours, nobody drank, we all just sipped water and sat around hugging each other and then went back to after parties. And then you know you drink and stuff like that when you are coming down. And then they introduced alcopops, because when you are on ecstasy you didn't want beer or something… Maybe some people have cider. But they introduced alcopops in the clubs, people started dying, because they were mixing MDMA with alcohol, and the effect, the impact it was having was horrible. They weren't able to dance for ages, they just turned into arseholes…"*
> *Senior Drug Advisor "Well it's back to what we were saying about alcohol. It was a very cynical move by the industry to trap a young generation of people, women in particular, but also men into drinking something sweet and not bitter, and apparently not toxic, but actually very strong. And it was a cynical ploy to get people addicted to alcohol, and it worked very well. You are the generation of young people drinking spirits whereas they weren't drinking spirits before, and then there were cocktails, and this again was a conspiracy by the industry, and government colluded with it, they sort of said well this is industry, this is revenue. And so you know liver disease started going up, women with cirrhosis at the age of 30 suddenly started going up, transplants going up, all sorts of things directly related. So alcopops was a disaster."*

The harm here was the encouragement by the alcohol industry to drink sweet alcoholic drinks to quench your thirst, as opposed to water. This is not to say that taking illegal drugs such as MDMA is harm free, but they are safer and more enjoyable taken in small, pure quantities without the addition of (too much) alcohol (Nutt, 2015). But that does not make much money.

Except for the legislative processes used to clamp down on this activity, and the moral panic surrounding ecstasy deaths in the late 90s, drug policy largely ignored, and continues to ignore, this group of drug consumers. The only area where we are legitimate voices is in the area of harm reduction, however, as we will see in chapter 7 even this is limited, and more recent harm reduction initiatives such as drug checking in festivals and clubs have not been acted upon. Harm reduction appears to predominantly focus on reducing the harm of 'problem drug use', as opposed to reducing the harm from all drugs use, and as a term/concept it did not feature strongly in the data. It is for this reason I do not spend much time on what harm reduction is, or how it is implemented in Scotland.

This ignoring, or silencing, of certain kinds of drug use speaks to #4 WPR question of 'where the silences are in the representation of the problem'? As we are beginning to see, the main silence is around drug use for pleasure, fun and therapeutic value.

At the same time that psychostimulant drug use was increasing, heroin use continued to escalate. The Retired Police Officer again, on his experience of the early 1990's heroin scene:

"So, the heroin situation just escalated and escalated and that was when we saw more and more initiatives… By the time we got into the 90s I went to CID, the drug squad in Berts Street, and then Easter House in the north of Glasgow between '85 and '90. These were really rough areas but there was drug dealing, but the drug dealing was just supplying like an undercurrent of drug users, it was still… The main issues were violence and alcohol. But behind that they start to set up the drug dealing business because they saw the money that could be made. But it was a demand driven market, we lived through Temgesic, (opiate based pill). So you saw them identifying that there was money to be made, and the more the people that took it the more people that said 'go on try that'. And the cannabis market definitely grew because of shipping availability, and heroin was very much the same, coke (cocaine) still never appeared.

The Retired Police Officer is identifying the growth in criminal gangs using drug dealing as a source of income. As he says, it was a demand driven market, people wanted the drugs, so the gangs supplied them. As we saw from the 1980s, the demand was a complex mix of situational pressures such as the disintegration of communities, lack of employment, and an anti-authoritarian sentiment.

This Senior Policy Officer was working as a support worker at the time:

"At one time in Glasgow, in Scotland, I'm sure the whole of the UK, we had a whole group of people who, they were highly employable, they were just unemployed cos there just weren't any jobs. But in the time that I did that work it became apparent to me there was less and less people like that, and there were just more and more people who were unemployed and just had huge issues."

By the mid 1990's support services were starting to see people who had over 10 years of social deprivation behind them, and little in the way of education and employment. It is around this time the authorities realised this 'problem' needed more than a few needle exchanges and methadone programmes.

The Retired Police Officer again:

"And then it just started to grow (the amount of heroin use). The police started to look at law enforcement being the answer. Going back, Strathclyde Police appointed a Force Drugs Coordinator to start to look at engaging with services. Back in 1994 it was Barry Dougal, and I worked with him, we worked the two of us one-to-one. And we start at

engaging with NHS, the drug courts, looking at drug related deaths because the drug related deaths figures fluctuated, I can't remember what year it was but there was 51 deaths in one year, and we thought okay that's surprisingly low, no rhyme nor reason."

Interviewee #6 was instrumental in setting up inter-agency dialogue around problem drug use. In 1994 the different agencies dealing with the fallout of problematic drug use had little interaction. The police arrested, the courts passed judgments, social workers dealt with families, and the NHS did not know how to deal with it at all.

The following Drug Policy Advisor was a Trainee Psychiatrist in a Glasgow hospital during this time, and his view of drug users was common amongst his peers:

"You know you would see half a dozen injecting drug users wanting treatment every night when you're on call. So it was a very unusual and unpleasant environment. and I have to say my view of drug users and managing drug users at that time, if someone had said to me you're going to become an addictions specialist, I would have laughed in your face, it was just such a…it felt like you couldn't offer anything, like you didn't have anything to offer. It was unpleasant, it was just not nice."

What we can see here is that it is not just the individuals using substances (in particular heroin) that had a sense of hopelessness and despair, but the service providers also felt a sense of hopelessness at their inability to respond to the increasing numbers of dependent heroin users. At this time there was still a lack of understanding that the cause of such use was largely systemic: that the conditions of the communities and lack of social investment was main driver of 'problem' drug use. Service providers were being inundated with cases they were unable to address at the root cause.

This started to change in the late 1990s when the Scottish Parliament was set up, and both the UK Government and the Scottish Executive began investing in drug policy. This Drug Policy Advisor was a policy adviser to the Scottish Government during that time and takes us through this period:

"And then in 1999 you have a Labour Scottish Parliament Government, and they produce a strategy which was, well it almost epitomized the Labour party because it was really heavily influenced by the English Labour Party[15]*. Because when the Labour Party got into power in Scotland they were very obvious, if you were involved in government, they were being worked by London. And drugs was a very big thing for Tony Blair's Government. They had a Drugs Czar, a guy called Keith Halliwell, who was a policeman with a very very good suit [smiles], but also a bit of a difficult guy. And they drove everything by…I mean he was based in the Cabinet Office, so he was based in No 10, so*

[15] Cabinet Office, 1998 'Tackling Drugs to Build a Better Britain'

anything the Scottish Labour Parliament were doing was very heavily influenced by the UK Labour Party.

So what happened, I mean SACDM[16] *after the 1999 strategy recognized - or Angus McKay*[17] *and his people recognized - that the problem in Scotland was not going to be investment, because he'd secured investment (10 million). The problem was going to be whether that investment had any impact at all. And the reason for that was a number of things. One thing was we had drug action teams (DATS) which were the local area kind of planning group, which were funded by the Scottish Government - the Scottish Office, the Scottish Parliament and then the Scottish Government - and quite significantly.*

So Angus McKay started working very hard to change that, to get better membership, user involvement, community involvement, much better involvement in the committee, because SACDM was just seen as a kind of talking shop and it became a much better thing. He also invested in the development of DATS into much better groupings, and that's because DATS had been evaluated externally at great expense and found to be awful: ineffective, lots of money for nothing. So he invested in that, and the delivery infrastructure was improved. So we had money, which people were going to be ready to spend, and he had… Basically all the DATS had the away day meetings, and they had development officer people helping them to become, apparently, better committees and better organizations and better partnerships."

This Drug Policy Advisor is telling us about the institutional changes that took place in order to better integrate drug policy (treatment) services, as a result of the growing recognition that the problem of injecting drug use was not going to be confined to the 1980s. Money needed to be invested, and there needed to be an impact. In 2001 the Scottish Executive published their Drug Action Plan in which they stated that the aim (impact) of the plan was to prevent young people from using drugs, prevent drug related anti-social behaviour, enable treatment for drug users and to 'stifle' the availability of drugs' (p 10-11). The problem, as they saw it, was that drug use resulted in increasing criminal activity, had become more accessible to young people, was linked to unemployment and homelessness, and prevented people from achieving a fulfilled life (p 3-4). By 2001 therefore, we can see that drug use has been firmly rooted in a 'problematised' narrative focusing on the harm attributed to such use. While there is an understanding that the type of drug use being focused on was a result of social inequality and trauma, there is no mention of the other kinds of drug use or using behaviour. Furthermore, despite this growing understanding, there was a strong enforcement narrative that drove much of the policy. As this Ex Scottish Minister #2 recalls:

"Well I was a Minister from 1998 to 2001, which was the first few years of Scottish Parliament, so is absolutely the beginning. And it was all during the period which Labour - who of course was the lead coalition partner then – Labour was… well it was developing

[16] Scottish Advisory Council on the Misuse of Drugs
[17] MSP 1999-2003, Deputy First Minister 1999-2000

its own sort of the Blairite tough on crime tough on the causes of crime. But in my view… in my view they kind of lost the plot - just got completely carried away with being tough on crime, as opposed to being tough on the causes."

Between 1999 and 2003 there was a focus on drugs policy by both the UK Government and the Scottish Executive. In 2001 the UK Home Affairs Select Committee announced it would hold an inquiry into drug policy. The subsequent report 'The Government Drugs Policy: is it working?' (HAC, 2002), explicitly outlines the focus of drug policy going forward:

"We believe it is self-evident that by focusing on the relatively small group of problem drug users, the Government could have a significant impact on the harm caused by such drug us" (para 24).

"We believe that drugs policy should primarily be addressed to dealing with the 250,000 problem drug users rather than towards the large numbers whose drug use poses no serious threat either to their own well-being or to that of others" (para 38).

The report goes on to detail what it considers problem drug use to be:

"Most harm is caused by and to the group of users commonly classed as "problematic". These are users who are often dependent on crack cocaine and/or heroin and perhaps other drugs, who live extremely chaotic lives with high levels of risk to their health and that of others, and are often involved in crime" (para 21).

We can see here then that the focus on this small cohort of drug consumers is one of the underlying presuppositions that has resulted in the representation of drug use as being harmful and problematic. It is acknowledged that this cohort are not representative of the larger drug using community, and indeed they heard evidence that:

"Those people who are involved in chronic misuse of drugs are generally damaged and it is the underlying causes we need to look at...most drug misuse is a symptom and not a cause. The same stuff will go on in those people's lives, abuse, poverty, unresolved bereavements, being in care, drug-dependent parents, the same stories come out again and again and again, and if you tackle those issues those people will not get into those problems in the first place" (para 22).

The report further states that: "[*W]hile around four million people use illicit drugs each year, most of those people do not appear to experience harm from their drug use, nor do they cause harm to others as a result of their habit"* (para 20). Yet despite this, there is no further discussion on the impact drug policy, in particular enforcement of the Misuse of Drugs Act 1971, will have on this larger

cohort of drug users. As a result, the focus of policy is on the harm of drug use, and other experiences are silenced and ignored.

In Scotland, the Scottish Executive turned their attention to this small cohort of problem drug users by investing large sums of money in various treatment and enforcement-based policies (Scottish Executive, 2001). To address this they set up the Effective Interventions Unit (EIU), "*a kind of unit within the Drug Policy Unit, whose job was to review the literature, review the evidence, produce guidance, produce standards and ensure that services were meeting those standards across Scotland"* (Drug Policy Advisor).

The EIU set about producing a series of reports focused on drug treatment (2002, 2002a) and integrating care for drug users (2002b). The new money outlined in the 2001 Drug Action Plan was starting to be spent, and drug services were beginning to focus on the concept of recovery as a way of creating pathways out of drug dependence. Alongside this, the first example of a citizen's jury on drug policy in Scotland was convened by the 'Glasgow Alliance' (no longer functioning or available online). This event spanned over two years (1999-2001) and findings were fed into Scottish policy being developed at the time (Glasgow Alliance, 2001). For example, the report recommended the creation of dedicated Drug Courts, and the first one was set up in the autumn of 2001. However, despite the flurry of activity surrounding problem drug use, drug related deaths were increasing, and in 2003 the media began to report on this:

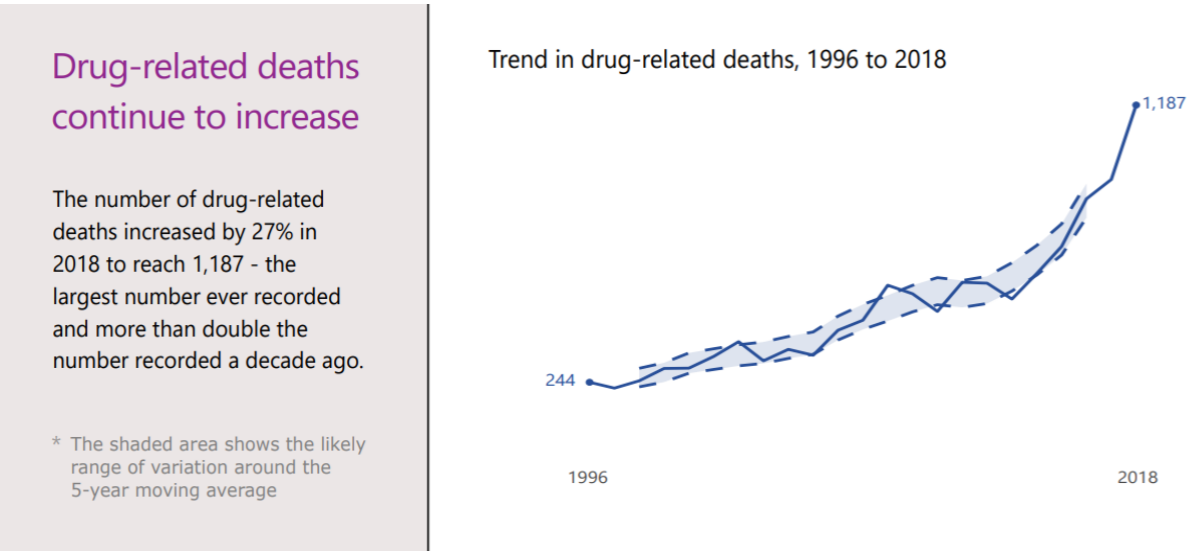
> *"And what tends to happen in the field is that there is some kind of uproar about something and is often about deaths or children dying or something. Something happens. And round about 2003/4 there's a big concern about drug deaths, and so the government decided to invest in drug deaths research*" (Drug Policy Advisor).

In 2003 there were 385 drug related deaths, and this topic began to be picked by the media (BBC Scotland, 2003a & 2003b). What I found interesting when reviewing this data, and listening to my participants recount this time, was how similar the narrative is to the current one. Indeed, the narrative of the older problematic drug user who has suffered as a result of social policies enacted during the 1980s seems to have started around this time:

> *"Users with a long history of drug use are at particular risk because of the long-term impact of drugs on their bodies…the figures underline the continuing need to tackle the root causes of problem drug use as well as improve the wide range of treatment, service and education necessary to minimise harm to drug users"* (BBC Scotland, 2003a).

Sixteen years later and this narrative is firmly embedded in much of the literature and minds of the drug policy community. At the time it was a relatively new understanding, in Scottish policy at least, and there appears to have been a belief that by focusing all the attention on this small group of

complex problem drug users, there would a reduction in drug use and drug harm (Scottish Exec Drug Strategy, 2001). Yet, over the last sixteen years there have been several 'uproars' regarding drug related harm, and deaths in particular, which have continued to increase (see box 1).



Box 1 National Records of Scotland, July 2019

The Scottish Executive responded to the media furore by commissioning a drug death review (SACMD, 2006). Interviewee #2 and his colleagues in SACMD brought a wide range of researchers together to review every drug death that took place in Scotland in 2003 and report of their findings, with recommendations:

> *"And that was interesting because what we did then is basically what people are doing now, so it hasn't moved on. People are doing what I would call a psychological autopsy on deaths. So basically they look at a big bunch of people that died, and say look lots of them are male, most of them are like this and lots of them are like that, and something must be done. And you go well we know that, the question is 'is there anything we can do that is likely to impact, get back to impact again, that can impact on this'. And that would require a particular type of research approach, which is actually what we're doing now (with the new Drug Network and Research Scotland)"* (Drug Policy Advisor.

The 2006 SACMD report made a range of recommendations on improving responses to overdose, improving and developing existing approaches, targeting those at greatest risk and service provision. Their final reports, Reducing Harm Promoting Recover, and Essential Care in 2007, paved the way for the Road to Recovery in 2008.

There are many important moments during these years which are outwith the scope of this thesis. The important point to pull from this period is that the reports from the UK Government on what the focus of drug policy should be, combined with the rise in drug related deaths, and the

surrounding political and media attention in 2003, was what initiated the current master narrative that runs throughout Scottish drug policy discourse. This narrative is of the individual who has a complex history of trauma and uses substances in such a way that it affects the mental, physical, social and financial well-being of themselves, and those around them. This narrative describes a small cohort of illegal drug users, but is almost the sole focus of drug policy.

In response to this narrative the Scottish Government focussed on an emerging philosophy of recovery, and sought to implement this into Scottish drug policy strategy going forward.

Summary

This second chapter in Historical Legacies developed the narrative around what the silences are (WPR #4) and continued the analysis around how the representation came about (WPR #3) and what presuppositions underlies the representation (WPR#2). As we saw, recreational, social and so called non-'problematic' drug use received scant attention from policy makers except in the area of criminal justice. The reasons why people were using, the spaces they were using in, and the enjoyment many got out of using were ignored and in some cases deliberately silenced. This silencing and ignoring of certain drug using communities begins to highlight the competing narratives within drug policy – that of the recovery agenda versus the human rights/criminal justice agenda.

The recovery agenda in general seeks to take people who are using drugs and help them 'recover'. While this is laudable, and will be explored more below, the underlying premise is that people want to stop using drugs, that drug use is bad for you, and that the goal of policy is to help people move away from drug using lifestyles. Conversely the human rights/criminal justice agenda can be seen as the collective of individuals who use drugs, regularly or not, enjoy their use (usually) and are in fact more harmed by the criminal justice systems interventions in their drug use, thn the drugs themselves. This narrative will be developed in more detail in chapter 9 where I set out policy narratives that contrast these two visions.

Chapter 6

The Road to Recovery and Beyond

The Scottish Government's drug strategy published in 2008 - the Road to Recovery - was seminal in that it was a cross party strategy put in place by an SNP minority Government which combined both criminal justice interventions and public health approaches under the banner of recovery. The concept of recovery in the Strategy was that individuals should be supported through their drug use using multiple responses including medical treatment, psychosocial treatment (community support, counselling etc.) and broader support in the form of addressing underlying factors such as poverty and deprivation (Road to Recovery, 2008, 23). In this way it highlighted the role broader societal conditions have on problem drug use, and created a role for the wider community and local government in addressing these issues. Problem drug use became a social issue, and recovery became a community response.

At the same time that the Scottish Government were working on the strategy, two other important documents were being written and published: The Royal Society of Arts, Manufactures and Commerce Commission (RSA) report entitled Drugs: Facing Facts' (2007); and Scotland's Futures Forum (SFF) report, Approaches to Alcohol and Drugs in Scotland: A Question of Architecture (2008).

The RSA Commission published their report in 2007 and were looking at UK wide policy, but their Scottish Commissioner was one of my participants, and her informal contact in Scotland was another one of my participants. The report's main objective was "*[t]o examine, as an independent body, all aspects of the relationship between public policy and the use and abuse of illegal drugs*" (RSA, 2007:4). Their main finding and recommendation was the scrapping of the Misuse of Drugs Act 1971 and subsequent legislation, which was to be replaced with a consolidated Misuse of Substances Act (RSA, 2008:310). This new Act should encompass all substances (including alcohol and tobacco) and should be focused on the harms caused as opposed to drug use per se. Possession and use of drugs would effectively be decriminalised, until such use started to cause harm.

The Scottish Futures Forum (SFF) is the Scottish Parliament's futures cross party think tank, owned in whole by the Scottish Parliament's corporate body. Its remit is to research and stimulate discussion on challenges facing Scotland, and to enable MSPs to have a long term view of how decisions made today will impact the future[18]. Their alcohol and drugs report was published in 2008, two weeks after the Road to Recovery, and received a lukewarm reception according to the participants involved. It utilised a systems approach which identified seven key areas which they used to explore the narrative of drug policy at the time, and how the narrative could be changed over time in order to reduce the harm of drugs by 2025 (SFF, 2008: 12).

[18] See www.scotlandfutureforum.org for more information

It was not until I had interviewed some of the participants involved that I understood how closely interlinked these three documents were, and how they constitute two major competing narratives emerging from within Scottish drug policy communities: public health-based reform, and legislative reform. Public health-based reform policy is based on the current legislative and constitutional framework of Scotland. The Road to Recovery represents this reform, with the focus being on public health responses such as treatment, education and engagement (all devolved aspects), and enforcement via the current legislative framework of the Misuse of Drugs Act 1971 and surrounding legislation. Legislative reform on the other hand seeks changes in the legislative and constitutional landscape. Furthermore, the narrative of public health-based reform sees problem drug use as the main focus of policy, embedding policy responses in a problematised harm narrative (the harm paradigm), with criminal justice interventions as a core component. In this narrative, other forms of drug use are ignored or silenced because they do not fit the narrative of harm. Legislative reform on the other hand recognises that people take drugs for a myriad of reasons, and that the harms stemming from drug use are a result of wider societal factors. While still framing the issue around a problematised harm narrative, there is recognition that criminal sanctions for drug use are limited in their effectiveness, and are based on moral ideology as opposed to evidence of harm (RSA, 2008, 284-300; SFF, 2007, 35).

The years following the implementation of 'the Strategy' up until the policy refresh in 2018 were dominated by the development of the recovery agenda. Outwith Scottish drug policy developments there were important shifts in the wider narrative of drug policy, and this section will explore how these competing narratives developed and started to merge.

The Road to Recovery - Consensus or Competing Narratives

The 2008 strategy was billed as a consensus strategy, but the reality was slightly different:

> *"The political history of the Road to Recovery is important. So this is a document which got through the Parliament by being supported by a minority SNP Government with the backing of the Conservatives, who fought through that budget, asked for two concessions from the SNP, one of them was on drug policy*[19]*. [A]nd within the Road to Recovery, the thing that they wanted was 'towards abstinence…drug free'…so that was the main driver behind it. It's then got cross party support, eventually, no one's willing to say anything against it. I have to say to be fair to the government, the politics and the parliament, the last thing you want is a really contentious strategy and for everything to be politicised in that party sense. So they managed to maintain a consensus, and they done that by cleverly going back to the Parliament setting up an ORT* [20] *review group to say that methadone works in Scotland and all the rest of it, to keep all the parties on board, and they've done*

[19] The other was a reduction on business rates.
[20] SACDM, 2007a

that very well. But actually, are we really saying that the point with treatment is to achieve abstinence, and if we don't do that we are failing, and if we're doing that, lets' do that – it wouldn't be what I would advocate, but this is what's happened in England where it is more clearly a conservative agenda. but in Scotland we've fudged the issue around what means what, for good reason, because we don't want to go there" (Senior Policy Advisor).

In addition to the competing narratives of pragmatic or legislative reform, we are beginning to see the emergence of another competing narrative that dogged Scottish drug policy for many years: the lack of clarity around what constitutes recovery, and by extension what the actual purpose of the policy is: to reduce harm or to encourage individuals to live drug free lives. These narratives intertwine with one another, with the pragmatic/legislative narrative becoming more important once the aim of Scottish drug policy is made clearer in the 2018 refresh. During this time however, the tension that developed as a result of the lack of clarity is what dominated my participants' stories. This Senior Civil Servant was part of the Scottish Government's Drug Policy Unit at the time:

"Well I think there was one story, but people viewed recovery very differently. So, everyone could talk about the Road to Recovery and the strategy and the consensus around it but actually ultimately it looked like consensus, but under the surface there really wasn't consensus."

This tactic of creating ambiguity in policy is politically essential in gaining consensus on issues which cause diverse opinions (Stone, 2002, ch.6). By gaining collective consent for the concept of recovery the Scottish Government were able to implement a policy that would have otherwise been contested by the opposing parties. This lack of clarity impacted the way in which the policy was implemented.

Delivering Reform

In order to implement 'the Strategy', the Scottish Government set up a Delivery Reform Group to examine ways in which the policy could be brought into effect (Scottish Government, 2009). The Drug Policy Advisor again:

"...So, Delivery Reform was created, very coherent approach, they invested in things like the Recovery Consortium, trying to do new things, and they invested in the Drug Strategy Delivery Commission (DSDC). They had closed down SACDM, 'cause they felt it was a talking shop and it wasn't that valuable.

I agreed... and they wanted to come up with an independent commission (the DSDC) which I thought was really incredibly good news. They said you can get who you want on it, you can set it up how you like, you will have your own secretariat who will be employed by the Scottish Government but they will not be accountable to the Scottish Government,

so everything...there's what is called a Chinese wall - not sure if you are allowed to say that - but a wall between you and them, so you do your own stuff, it's independent. So we did that. We started working, and that was really interesting and really exciting, and I really really thought we are actually gonna make a difference, it's going to be possible to make a difference. And we worked very very hard, and did some very good things."

This Drug Policy Advisor hopefulness that the strategy would deliver the impact the community sought was indicative of the narrative of this time. The strategy gave the community a position to work from: implementation of essential care based on the concept of recovery so that problem drug users can be helped to work towards a drug free, and by extension a fulfilling life. Delivery reform had its challenges though:

"well we were trying to do it collaboratively with stakeholders, with partners, but yes, at times I had to do some quite tough things that weren't very popular because… an example would be around the recovery consortium (SRC), which didn't feel to me when I first took over the role (in 2009) that it was really going in the direction that we wanted it to. We were looking at community recovery so we had to do some quite tough things around that. We did have some really difficult things around the drugs commission (DSDC), and part of my role was really more around trying to keep the political consensus around the strategy to allow the investment to be made and the work to be done, because it wasn't going to be a short term fix.

...And you know, there was some quite difficult conversations about trying to get the money out from the health boards and to set up services. Trying to get the…I suppose we described it as trying to hardwire the house in a way that made it more likely to deliver recovery, and it was quite boring but it was things like how to do you re-train your workforce, how do you ensure that you've got governance in the community so that community planning partnerships care about this. How do we actually have data that shows outcomes and improving. It was all of that. And so trying to create that environment…[making sure] you've got the right kind of delivery mechanism to start effecting change. Trying to keep other politicians on side, particularly trying to hold the ground around methadone actually, because the evidence base was you know, it was a reasonable thing to do, you know, there is clinical evidence around all of that. But … And I think the other thing was keeping the money so, you know, spending reviews went through in 2010 arguing why Justice money was being spent on these health service" (Drug Policy Advisor).

With delivery reform underway, the independent DSDC set about monitoring its implementation and preparing advice for the Minister to take forward. As mentioned by the Senior Civil Servant there were some difficulties surrounding the DSDC which they would not elaborate on. The Drug Policy Advisor however has a viewpoint on the matter:

Drug Policy Advisor: "But the first year we took lots of evidence on work and we presented our first report to the Minister[21]*. The week before I was at a conference the Minister was at, and he was asked 'do you think the Road to Recovery is working', and he said well it's not for me to say whether the Road to Recovery is working, we have a Drugs Strategy Commission which is an independent commission who are about to give us their first report, and we shall hear from the senior Dr Brian Kidd next week, whether or not we are successful'. So I went along and said him 'not very successful', and he fell out with me, and that was that. And essentially from that day on the DSDC was seen as...difficult because we...*

Interviewer: "So were you making recommendations that were effectively, potentially unachievable in the current climate? I mean what was..."

Drug Policy Advisor: "No no no, no. We were simply not producing a report that said the government is doing really well."

Interviewer: "ahhh...right, okay"

Drug Policy Advisor: "And that's the awful thing. Cos I suspect, behind closed doors they would say we understand that, we want constructive feedback, which is what they were getting. But they actually don't, because what they want is the report...I mean what they say to you is 'look, you're independent, you can publish your report saying that if you want, it's just that we'll have to defend ourselves'. But I thought we were part of this machinery, our job is to try and say to you 'look guys, if you do this we want to input...the evidence base says we should be doing that, and you're not doing that'. And your not doing it because it is really hard for central government to influence local delivery, effectively. So we're wanting to give you more strength to your arm, to make the things you want to happen, happen."

Interviewer: "So is that what led to the dissolution of the DSDC?"

Drug Policy Advisor: "Ultimately, ultimately."

The 2011 report was not scathing of the Scottish Government, indeed it recognised that there had been significant investment and implementation of key actions set out in the 2008 strategy (DSDC, 2011, 14). The report recommended that the government bring alcohol and drugs under the same team (by implication they should be under the health team), that it improves its 'institutional memory' (22), and overcome barriers to local delivery of national strategies (23). However, the recommendations would have required the Minister, and their civil servants, to work harder at making sure local delivery was in line with national priorities. This would require further investment in time and money, something it appears they were not willing to do.

While the DSDC may have come across difficulties resulting from political pressure, the Scottish Recovery Consortium (SRC) on the other hand went from being initially problematic to a

[21] DSDC, 2011.

success story that is still going today. Here the CEO at the time talks about the initial few weeks when they took over in 2011:

> *"Em, well the great thing about taking something over that's in a shit storm*[22] *is they're just glad you turn up. And so I was deeply inspired by the Drug Policy Unit.…We created new forms, we used conversation cafes, we created the recovery colleges where we developed the activists. Me and a mate both on the back of a fag packet after the very first conversation café that we attended – first week of my job – we could see there was something trying to happen and it needed help now, and we couldn't wait, so on the back of a fag packet – cos I was still smoking obsessively – we wrote up this idea that we called the recovery college – let's do it. And within 6 weeks we had the very first recovery college students up and running*" (CEO of Drug Charity).

As you can see, the Road to Recovery initiated a raft of changes that radically altered the way in which the Scottish Government engaged with drug policy. There was enthusiasm and hope surrounding the initial phase, but this hopefulness began to wane towards the end of the period:

> *"Drugs policy is populated by people who have been involved in policy for many years and are either entrenched in their views of what drug use is and who the drugs user is – ie problematic users – or weary and saddened by the lack of going forward regarding policy"* (Senior Drug Advisor).

However, it is important to pick up that the narrative which policy engaged with most was the recovery narrative. As we have seen recovery was a concept which enabled cross party support, albeit with ambiguity at its heart. The DSDC on the other hand presented the government with challenges which they were unable, or unwilling, to take on board at that time.

Missing from all of these policy initiatives is the 'non-problematic' drug consumer. The strategy is almost silent in regards this kind of drug consumption except to situate it in a problem/harm narrative by stating: "[*T]he Government is committed to tackling recreational drug use through improved education, information and enforcement of the law. Recreational drug use today can become problem drug use tomorrow."* (Road to Recovery, 2008, 2). However, in 2009 the Scottish Government conducted research into the scale and impact of illicit drug markets in Scotland (Scottish Government, 2009a) which found that there was an estimated 199,977 'problem drug users', and 624,234 so called recreational users (23). The policy therefore only addresses one third of the drug using population. Given the data was sourced from two surveys: the Scottish Crime and Victimisation Survey, and the Scottish Schools Adolescent Lifestyles and Substance Use Survey, and many of us who started our drug using careers in the rave scene of the 1990s will have not participated in either of these, it is reasonable to conclude the 'recreational' use is indeed higher. It is also reasonable to

[22] The initial set up of the SRC was complicated, and the interviewee had just spent some time explaining this.

assume this as most drug use is illegal so it is difficult to get honest answers and that marginalised groups don't fill out the surveys as you have to be in stable housing or schooling to participate

While in Scotland policy grappled with how to implement the Road to Recovery, and roll out recovery orientated systems of care, large shifts were taking place in regards drug policy governance. This is important because the recent changes in narrative evidenced by the 2018 Scottish strategy Rights, Respect and Recovery (discussed in the following section) were influenced by these shifts, in particular the UK Drug Policy Commission's wide ranging report on governance.

Shifts in Narrative

In 2012 the UK Drug Policy Commission (UKDPC) published a report into drug policy governance in the UK. The Commission was an independent commission with a mandate to look at how far national drug policies were routed in evidence. Essentially they set out to explore whether they could identify what a good governance framework is, to examine how drug policy is made, developed, implemented and scrutinized.

Core recommendations from the report were:

1. Create a cross-party political forum to progress discussion about future policy, including engaging with the public.
2. Move the political lead from the Home Office (justice led) to the Department of Health.
3. Ensure drugs strategies are evaluated from the start.
4. A new independent body should be established to co-ordinate the drug research effort and provide analysis.
5. Develop deliberative methods for engaging with the public around the goals and options for drug policy.

The commission published a range of findings setting out what makes good governance:

1. Clear overarching goals
2. Effective leadership
3. Good coordination of policy efforts
4. Policy design with options & evaluation
5. Development and use of evidence
6. Implementation resources & flexibility
7. Accountability and scrutiny mechanisms
8. Stakeholder engagement

They compared the current UK policies with the findings of what makes good governance and found that:

1. Governance structures were inadequate
2. There are unclear and contested goals
3. There is limited evidence of impact
4. Inability to audit and assess effectiveness and value for money

In 2016 SDPC held a governance workshop presented by Roger Howard, a commissioner on the UKDPC commission. He was familiar with Scotland because he had been invited to get involved with various advisory groups looking at how to implement the UKDPC recommendations. The following is an extract from his presentation:

> *"When it comes to thinking about the formulation and implementation of governmental policy on drugs then Scotland fared better than England. Better insofar better that a lot of the policy actors were pretty well rehearsed and engaged in shaping and influencing. This may have been a function of size of the country or behaviours, or perhaps the politics of devolution. But, I think there was a very obvious attempt to do things like policy analysis and logic models, to look at things like effectiveness. In fact the Scottish Government had set up its own effectiveness unit. Of course I could have a go at them for doing away with it. I'm sure there are rational reasons, but you know it did originally commit itself to try and build an evidence base. It also had an implementation scrutiny mechanism involving independent experts. For all its faults and limitations - I was a member of it so I know some of them – the Scottish Drug Strategy Delivery Commission did provide a bit of architecture around drug policy implementation. If you look at Westminster there's nothing like that, there's nothing that will enable that dialogue between government and other interests to really genuinely take place. But we know, landscapes change, events change"* (Roger Howard, UK Drug Policy Commission, CEO, SDPC Governance Workshop, 2016).

Many of us in SDPC were unaware that the UKDPC Commissioners had been involved in advising the Scottish Government on how to develop good drug policy governance, so this workshop, and acknowledgement of the role being played, was important in understanding how the narrative of drug policy was developing. It was apparent from the recent changes in drug policy governance that some recommendations had been acted upon, for example in early 2016 the lead for drugs policy in Scotland was moved from the Justice Department to the Health Department. At the same time a new independent (non-governmental) advisory framework had been set up (Partnership for Action on Drugs), which had broadened the remit of policy to include drug harm more generally, and had a strong focus on prevention and community solutions. Yet there were many areas that had yet to be addressed, and I will start to tighten the focus on one particular area, participation of stakeholders, in order to delve deeper into the research contributions.

During the course of the discussion following the UKDPC presentation there was discussion on reform, in particular around greater participation of people who use drugs in policy formation, and the decriminalisation of drugs. One participant made a comment along the lines of:

> *"I think there is a distinction between the policy opportunity and the political opportunity. I think that part of the challenge is that academics/researchers etc. can develop as great an evidence base and robustness, and we can come up with this and we can collaborate and we can develop, and it can be done quite openly and quite in an inclusive way with the government. But until the politicians have a level and degree of comfort then the change will not happen. And this presentation is really helpful for policy makers because they are in that policy bubble that is trying to set policy change. They are doing a lot more around evidence and all these gaps are beginning to get focussed on including this issue about citizenship and* ***how they engage with communities, and they've started that conversation I believe***" (anonymised due to Chatham House Rules).

This comment shows a belief that there is a shift in narrative away from focussing solely on treatment options for problem drug use, to a desire to engage with a wider audience in order to address drug policy problems. The stumbling blocks are the politicians. While the structure of policy may allow for multiple inputs and options for engagement, ultimately it is the civil servants who write the recommendations as policy briefs/reports/bills or sign off the cheques, and the minister who rubber stamps. It is therefore possible to have a well written policy document, with a range of expertise and recommendations, yet little in the way of meaningful engagement on the issues going forward[23]. For example, the desire was laid out in the paper 'National Research Framework for Problem Drug Use' (Scottish Government, 2015) which called for a wider range of policy stakeholders to be involved in

[23] I am basing my observations and analysis on the landscape at the time. Much has changed in the world of policy, and recent initiatives have seen elements of both the 2013 document and the 2018 refresh implanted and worked on. In particular, work has taken place around the area of lived experience engagement – or peer led advocacy as it is often called now.

the policy process (10). The following is an extract of my notes on this discussion which I wrote while transcribing the workshop recordings:

> *"The conversation has indeed been started but the structure of the conversation is still very much dictated to by those that hold the power – the policy makers, the institution that is conducting the conversations etc. For example, the LII 3*[24] *discussion on 'seek keep and treat'*[25] *was presented as gathering voices, experience, knowledge and views on the new strategy, and there was a lot of deeply informative conservations which , if taken on board, could alter the way SG implements the strategy –education, trauma, prescribing, criminal justice system. However, there was a feeling amongst the group they were there to rubber stamp the new approach, that it would not alter the implementation. On a similar note the refusal to engage with MCRS to the point of discord shows how the SG are not willing to reach too broadly, or deal with issues that may be seen as politically sensitive. They have however engaged, to an extent with SDPC, but we are more formal, there is recognition of the kind of group/interest we are representing. Someone, in regards BM's*[26] *attempts to get SG policy representation, actually said to me on the phone something along the lines of 'there are ways of doing these things and she is not doing that'. They expressed resistance because MCRS appeared to be a one women band determined to get the ball rolling, and she was, but MCRS ultimately represent thousands of people seeking cannabis as a solution to medical problems, who are too scared to put their name to official papers, and the government should have reacted better"* (Field notes, December, 2016).

The groups mentioned in this extract will be explored in more depth in the following chapters, as will the themes arising from it.

Summary

This section ends where my data collection period starts, 2016. From here on in the focus of the thesis will be on the narratives surrounding one aspect of the data, participation of stakeholders in drug policy formation. In order to explore this using the WPR approach we needed to develop an understanding of the historical legacies and how these helped shape the representation of the problem.

This chapter addressed four of the WPR questions:

1) *What's the problem represented to be?*

   The problem in drug policy is represented as the impact that problematic drug use has on the well-being of individuals and society. As we saw, in 2001 policy began

[24] Live and Living Experience Group – discussed in the following chapter.
[25] The original title of the drug strategy refresh
[26] MCRS campaign manager

to explicitly focus on the small cohort of individuals who use opiate based substances, and their use is perceived to cause harm to them and their community.

2) *What presuppositions underlie this representation?*

Underlying this representation is the presupposition that drug use causes unacceptable levels of harm to the individual and society.

3) *How has this representation come about?*

This representation has developed as a result of an increase in opiate based drug use, combined with an increase in poverty and deprivation as a result of the policies of the 1980's. These policies resulted in the devastation of many industrial based communities, with job losses and lack of investment in housing etc. At the same time other forms of drug use were increasing, but their use was not perceived to cause the same amount of harm as dependent opiate use. As a result policy was directed towards the smaller, but more harmful, cohort of opiate based drug users.

4) *What is left unproblematic, where are the silences?*

The focus on harmful problem drug use has meant that other forms of drug use have been ignored, and at times actively silenced. People who use drugs but do not engage with treatment services, or do not use drugs to such as extent that they come to the attention of public services, are not the focus of policy.

Narratives

In addition to answering four of the WPR questions, this chapter also set out to map the master and counter narratives in Scottish drug policy communities that have emerged over the last 40 years. In doing so two narratives come through: one master, and one counter.

The **master narrative** is:

Drug use is harmful to the individual and society. Opiate drug use in particular has been causing harm in our communities for decades. The roots stem from the 1980's economic and cultural upheaval, and as such we have embedded problematic drug use. This use is linked strongly to deprivation, poverty and trauma, but ultimately the individual needs to seek to recover.

There are two aspects to this narrative:

1) People need help to stop using drugs problematically, and the focus should be on encouraging individuals to stop their drug use and enter into recovery. Recovery is supported by the government and you will find different services to support you on your recovery journey.
2) That sadly some individuals do not make it to the recovery stage and die from drug related illness/disease/use. Our job (the government, policy discussions, service providers and the wider community) is to prevent this from happening by focussing on the reasons why drug related deaths take place (poverty, trauma, lack of services etc).

The **counter narrative** is:

Drug use is pleasurable, and harm resulting from such use is often as a result of the criminal nature of the drug. Many people use drugs, but these voices are silenced or ignored by the focus on 'problem drug use'.

In summary the 1980s saw an increase in heroin use and increase in deaths from AIDs, resulting in the development of the problem/harm narrative. This section of the data focused on the development culture of drug use and the problem responsive policy developed as a result of the increase in opiate drug use and HIV infections. The narrative of current (2016 onwards) drug deaths being a result of the 1980s social policy is in part justified, but it is evident that responses from the more recent Scottish administrations have failed to address the overarching barriers to more radical solutions. The 1980s also saw the beginning of the debate in Scotland around abstinence or harm reduction.

As we progressed through the years the focus moves away from the culture of drug use to institutional responses. As a result, the policy narrative becomes more and more focused on 'problem' drug use, as opposed to drug use per se. Policy is explicitly directed towards problem drug users and the legacy of drug policy barely touches on so called recreational drug use usually associated with drugs such as cannabis and ecstasy. We see that despite an increase in so called recreational drug use resulting from the illegal rave scene, the only response is an increase in criminal sanctions through the Criminal Justice Act 1994. This silence in the policy arena is deafening, particularly to someone who has spent her adult life involved in multiple drug using cultures, and identifies as a recreational drug user.

The 2008 Road to Recovery saw a shift towards recovery-based policy responses, and the competing narratives of pragmatic versus legislative reform began to become more evident. Over the following 10 years policy continues to be dominated by narratives of problem drug use and harm stemming from such use. By 2016 it is clear that the policy is solely focused on problem drug use as a health problem.

The purpose of this section was to develop the understanding of what the problem is represented to be in Scottish drug policy, and how this came about. In doing so it addressed four of the WPR questions, and highlighted the emergence of master and counter narratives in Scottish drug policy development. As noted in the introduction, 2016 was the beginning of a raft of changes that are still ongoing at the time of writing, and these are explored in the following chapters.

PART THREE

Contributions to the Field of Knowledge

Chapter 7

Stakeholder Participation in Drug Policy

Introduction

> *"Calls for "evidence-based policy" and greater community "participation" are often heard in the drug policy field. Both movements are in different ways concerned with the same questions about how "drug problems" ought to be governed and the place of "expertise" and "engagement" in democratic societies. However, these calls rely on the assumption that knowledge's, publics, expertise, and issues of concern are fixed and stable, waiting to be addressed or called to action, thus obscuring ontological questions about what "participation" (be that lay or expert) may do or produce. There has been limited research in the drugs field that has taken "participation" as an object of study in itself and through critical examination attempted to open up new possibilities for its remaking"* (Lancaster et al, 2018, 351).

This chapter goes some way to filling the research gap noted by Lancaster *et al* by exploring my experience of 'doing' participation with different drug policy communities, and critically analyses this experience using the WPR approach. In order to do this I use three of the six analytical questions set out by Bacchi (2009):

4. *What is left unproblematic in this representation? Where are the silences?*
5. *What effects (discursive and lived) are produced by this representation?*
6. *How can the representation be produced, disseminated and defended, and how can this be challenged?*

In answering these questions this chapter will address a core research question: *What are the challenges in engaging different epistemic communities in a participatory process?*

The first part of this chapter will explore the literature on participation in policy, with a particular focus on expertise in drug policy. The second part will introduce my findings on participation using three groups that I was involved in: SDPC, LLEEG, MCRS[27]. My involvement with these groups reflects the different ways in which participation can be enacted, and the extent to which this participation may be meaningful. Using myself as the main character in the story, I chart how participation can range from being consultative (giving feedback on a set agenda) to being influentially involved (setting the agenda). Further, my involvement saw me as an

[27] For a refresher they are: The Scottish Drug Policy Conversations (SDPC); The Lived and Living Experience Executive Group (LLEEG); and the Medicinal Cannabis Reform group (MCRS).

expert/academic (SDPC), a representative of a community (LLEEG) and peer facilitator (MCRS), giving insight into different positions within policy groups. All three of these groups gave me an insight into how participation between non-institutional stakeholders and the government can be negotiated and sustained depending on the position (and ultimately the legitimacy) of the stakeholders. The final part analyses the findings of the chapter using Bacchis' WPR Approach. In doing so it develops the core themes of the research, and shows how meaningful participation is dependent on the structure and power dynamics of the group in question.

Finally, an important aspect of the following discussions is the concept of *meaningful engagement*. The experience of meaningful engagement is not static: it is dependent on the experience of the individual or group, and cannot be fully quantified. Therefore, for each group I briefly describe what meaningful engagement meant for them, or at least how I interpreted what it meant for them. Because I use myself as a subject, my own perception of what meaningful engagement entails is also relevant. The main focus is on the overarching process as opposed to analysis of the way in which groups were set up/conducted etc. The three groups are presented using a combination of auto-ethnographic narrative, written reports on the meetings, observational data, interview data, and documentary evidence.

From 'Evidence-led Policy' to Stakeholder Participation

In 2005 the UK Labour Government made a commitment to 'evidence-led' policy making, and in particular the use of 'robust' evidence in drug policy formation (Bennett & Holloway 2010). As discussed above in chapter 1, in the years following there has been growing understanding about the problems surrounding the concept of evidence, particularly regarding drugs (Stevens, 2011; MacGregor, 2013; Roberts, 2014; Bennett & Holloway, 2010; Duke & Thom, 2014; Stevens & Ritter, 2013; UKDPC, 2012).

While on secondment to a UK drug policy unit, criminologist Alex Stevens observed behaviours which highlighted problems with the use of evidence in drug policy formation (Stevens, 2011). Stevens found that while there was a high level of commitment to using evidence, there was often an 'over saturation' of evidence resulting in evidence being cherry picked to suit desired outcomes (Stevens, 2011). Furthermore, evidence was not used to challenge the conventional structures of power but to maintain the status quo and uphold the government's narrative of 'totemic toughness', which downplayed the role inequality and poverty plays in 'problematic drug use' (Stevens, 2011). This narrative highlights the use of evidence that supports a way of thinking that is comfortable with the unequal distribution of power and wealth (Stevens, 2011; Lancaster, 2014). Further, it gives weight to a constructionist viewpoint that, as a result of the *construction* of the drug policy arena, those whose voices are more powerful and fit the dominant narrative will be given space to speak (Lancaster, 2014; Monaghan, 2014).

It is argued therefore that evidence-based policy sets out criteria that is used to maintain a power structure that already exists (Stevens, 2011, 2018; MacGregor et al, 2014; Lancaster, 2014, Duke and Thom, 2014). This maintenance of dominant structures, through the use of evidence-based policy, supports the development of a critical drug theory outlined below, by highlighting the use of evidence that suppresses the voices and narratives of those less able, or willing to conform or engage in institutional policy development. Increasingly forms of evidence used to meet this criterion are being challenged as maintaining the status quo of power structures that exist within the institutions of policy making (UKDPC, 2012; MacGregor et al, 2014; Lancaster, 2014; Lancaster et al, 2015; Stevens, 2018). For example, randomised controlled trials (RCTs) are seen as the gold standard of all evidence production, however this form of evidence production does not allow for the more inclusive forms of knowledge generation such as consultations, deliberative workshops, stakeholder representation, and narrative based evidence (MacGregor et al, 2014; Lancaster et al, 2015; Epstein et al, 2014; Duke & Thom, 2014).

Non-professional (lay) participants can help policy makers understand how a proposed intervention will work, and give more insight into the social construction of the problem, and its goals (Epstein et al 2014, Colebatch, 2009, ch.3). However, it is argued they often lack cultural capital that is termed 'political' (May, 1992; Epstein, 2014) – the more nuanced understanding of the political and structural processes involved in policy formation. Further potential problems include co-option, tokenism and other ways in which lay participants (and in particular drug users) are involved, but side-lined, which I found to be true in my involvement with non-traditional stakeholder groups.

Professionals involved in the formal evidence gathering process are part of a 'community of practice' that understands how to present their ideas and evidence in order to have the maximum impact. The term 'community of practice' was first coined by Jean Lave and Etienne Wenger (1991), who explored this term in relation to the development of apprenticeships. It is now taken to mean the broader social learning and shared sociocultural practices that emerge from specific social groups, in this case policy professionals (Nuttall, 2010).

"The prominence of hard data, cost-benefit analysis, and formal premise-argument-conclusion reasoning thus constitutes an important element of the shared repertoire – a boundary object that comes to delineate 'legitimate' participation in the development of policy" (Jasanoff, 1997; Star and Griesemer, 1989; Fiorino, 1990; Epstein, 2014, 248).

Lay participants on the other hand present their evidence using personal and contextualized narratives that may include in-depth knowledge about the topic, but because of the way it is presented they are not considered impartial, or based on the reasonable assessment of the situation (Hampton, 2009; McDonough, 2000; Epstein et al, 2014). Stories in particular can be emotive

ways of persuading policy makers, as McDonough comments in relation to stories versus peer reviewed evidence:

> *"Stories can enable lawmakers to understand a legitimate need for policy change but just as readily can lead them to make bad policy decisions. Stories can bring to life drab data analyses, helping us to visualize problems and opportunities for change. But stories also can lead us down wasteful and dangerous paths and blind us to uncomfortable truths we would prefer to ignore, like the fact that there yet is no easy cure for breast cancer"* (McDonough, 2001, 209).

Drug policy is problematic therefore, because it involves 'normative and evaluative issues' which are embedded within the individual about how much weight to give to evidence (Roberts, 2014), and determinants of risk and harms are subject to influence from political and cultural narratives (Rolles & Measham, 2011). Stories and narratives are built into the framework of deliberation as a result of historical legacies, making it difficult to challenge. It has been argued that a way of breaking these structures is to broaden the concept of drug policy expert to include previously marginalised voices such as drug user representative groups and drug consumers (Glasby & Beresford, 2006; Duke and Thom, 2014; Lancaster et al, 2018; RSA, 2007).

Although the concept of user involvement in drug policy has been around for some time, it has only recently gained traction in mainstream institutional settings. For example, Public Health England have created a service user led treatment service (Public Health England, 2015), and researchers such as Alison Ritter and Kari Lancaster (2013, 2014), Betsy Thom (2014), Dorok (2014) and David Nutt (Carhart-Harris & Nutt, 2013) have investigated the opinions of drug users to help broaden to concept of policy expert to include drug consumers as stakeholders. In Canada there has been greater strides to include those with lived experience in policy development, since the release of *Nothing About Us Without Us* (Canadian HIV/AIDS Legal Network, 2007), particularly around harm reduction and injecting drug use. Since then, there have been various ways in which 'peers' have been engaged in policy development, with the 'Canadian AIDS Society' even developing an instruction manual entitled 'Peerology' (2015), on how to engage peers in local policy decision process. Peer engagement has been described as "*consulting and collaborating with decision makers using a bottom-up approach in order to better address the needs of the community* (Ti, Tzemis & Buxton, 2012, 47).

Australia has also seen the impact of drug user organisations, with the Australian Injecting and Illicit Drug Users League who regularly submit policy recommendations developed within their membership community. In Europe there is the European Network of People who Use Drugs (EURONPUD), who also attempt to affect policy change and greater involvement in policy processes. Indeed, one member of the Scottish peer network was part of EURONPUD, but has since stopped participating in policy meetings following the engagements described below.

Furthermore, Scotland's Road to Recovery (2008) began the discussion around engagement in its definition of recovery, stating that "*all services and commissioning partners must put service users at the heart of their activities"* (4). In developing this approach, the updated Scottish Strategy 'Rights, Respect and Recovery' (2018) calls for greater inclusion of 'lived and living' experience stakeholders in all aspects of policy formation in Scotland by calling for an:

> *"[E]vidence informed approach, which appropriately involves academic evidence, the voice of lived and living experience, family members, those with professional experience and other intelligence on alcohol and drug related harm and recovery"* (Scottish Government, 2018, 4).

Despite this increase in participation of drug users, there is growing criticism from a number of critical scholars on how this participation is enacted, including the 'problematisation' of evidence-based drug policy (Bacchi, 2017), and the way in which voices are legitimised in the process (c.f. Fraser & Moore, 2011; Fraser, Moore, & Keane, 2014; Lancaster, 2014, 2016; Lancaster, Seear, Treloar, & Ritter, 2017; Lancaster, Treloar, & Ritter, 2017; Ritter, 2015; Valentine, 2009). This growth in critical voices in part led to the development of critical drug policy set out in the following chapter, in order to 'house' the growing critique. Importantly it develops alternative paradigms to the harm narrative, in order to challenge the foundations on which most drug policy rests upon.

The following explores my participation with three different groups: SDPC, LLEEG, MCRS, all of which had an element of drug user engagement. The SDPC was not explicitly drug user led, however many of us involved in the process have used, or currently use illegal drugs. The two further groups were explicitly user led, with one focussing on the engagement of those with lived and living experience of problem drug use, and the other with people who use cannabis for medicinal or therapeutic reasons. I chose these groups because through exploring the different journeys of engagement, they highlight the master and counter narratives that run through the different communities, and show how different stakeholders are afforded different privileges depending on their status. My involvement with these groups generated a considerable amount of data, and here I focus on specific experiences during the processes that shed light on the dynamics between individual/group narratives, and the institutional narratives that constrain (or empower) them. From this I developed a typology of stakeholders with the aim of providing a heuristic to explore positionalities and perspectives as mobilised in participatory processes: the professional, the sick, the recovered, and the happy.

The reason I developed a typology of stakeholders is that during the analytical process it became evident there were different positions afforded to different groups/individuals depending on their perceived legitimacy within the policy process. At first the difference appeared to be

between those who had lived experience, and those who were 'experts'. However, the deeper I went, and the more reflection I conducted on my own engagement, the more it became obvious that there were several different layers of legitimacy that impacted how individuals could engage at an institutional level. The typology evolved out of this analysis and reflection to become the four types of engagement mentioned above, and which I develop below. These statuses, or typologies, are not mutually exclusive however: it is possible to be a professional and recovered stakeholder for example. However, in most instances I found them to exist on their own, as explored below.

The Lived and Living Experience Executive Group (LLEEG): The 'Official' Way to Engage

The Lived and Living Experience Executive PADS Group was set up to provide a pathway for the voices of people who have 'lived and living' (current) experience of 'problematic drug use'. I chose to use this group because I was involved from the beginning, and it highlights the challenges and positive outcomes engagement with this group can provide. Furthermore, the group was set up by the PADS executive committee to provide a pathway for lived experience representatives to attend the executive committee, and is therefore a good example of pathways to policy engagement. However since my data collection, two developments have happened. Firstly the suggestion by PADS committee members to include representatives from the LLEEG group on the executive committee was rejected (private communication with members). This was not communicated to the group and shows how disconnected drug policy governance in Scotland can be. Secondly, the PADS advisory structure was disbanded in August 2019 to be replaced with a Drugs Death Taskforce. Therefore, regardless of whether a representative was chosen or not, their involvement would have been short lived[28]. Despite these developments, my involvement with this group helped shape my understanding of how engagement is enacted, and may be conducted in Scottish drug policy in the future.

The development of the term 'lived and living' is in interesting one as it shows the implementation of what Fleetwood (2016) terms 'narrative interventions' during the course of the LLEEG journey. Narrative interventions, as described in chapter 2, are a well-developed technique in certain disciplines such as education (Fleetwood, 2016; Hochstetler et al., 2010; Presser, 2009). However, Fleetwood has argued for its incorporation into criminology in an attempt to change harmful discourse, as opposed to the perceived harmful individuals (Fleetwood, 2016, p.188). It is argued that such interventions have the possibility of creating harm by imposing the dominant discourse onto marginalised populations (Fleetwood, 2016). However, they can also be used to empower, by challenging the dominant language and initiating change to reflect the discourse of those who are marginalized. Exploration of these interventions in the following pages also

[28] There is lived and living experience representation on the Taskforce, but it is limited to 3 people.

highlights where the silences are/were (WPR #4), the effects of the problems representation (WPR #5), and how this representation can be disrupted, questioned, challenged and replaced (WPR #6). Meaningful engagement for this group of participants was not uniform, with some seeing the setting up of the group itself a form of meaningful engagement, and others seeing the whole thing as a charade, with meaningful engagement requiring power at the agenda setting stage (executive group/direct links to Ministers).

Are we Lived, or Living?

The term 'lived experience' was initially used to describe someone with experiential knowledge of drug treatment and recovery services. During the course of its development, it was acknowledged that people who currently use drugs should also be involved in the process, and it was expanded. This is an example of a narrative intervention. I was part of the first LLEEG meeting that started to 'disrupt' this term and my reflections on this specific point were as follows:

> *"I found the process very moving – in regards who is the drug user in this narrative it is most definitely the reformed user – those who have gone through the recovery process and are now 'clean'. Yet, at the same time there was a recognition that there are voices missing from the conversation – that of the living drug user (i.e. those who still use drugs and are not interested in stopping).*
>
> *Even with the awareness that the living experience is missing, there seemed to be an unwillingness to properly address the fact that we are only focusing on those whose drug use appears to have caused a lot of harm, to themselves and their families. When I tried to get clarification on whether they mean all drug users I was met with nods of agreement, but a silent feeling that I was trying to bang a drum for something that was not worth the time* (field notes LLEEG, 2017).

My attempt to get clarification on the exact kind of living experience is reflective of my personal agenda. I have found that there is general agreement within the policy community that Scottish drug policy is directed towards those that appear to cause the most 'harm', and this is logical, as I showed in Part 2, Historical Legacies. The issue lies in the fact that drug policy, both reserved and devolved, affects *all* drug users. As a person who has used drugs for decades, and interacted with many drug using communities, I have seen and experienced this. My personal agenda, this rearing up of my internal sense of injustice, was something I struggled with throughout the research process. Personal agendas aside, the extract show us that the discussion began to give voice to the previously ignored - those who currently use drugs - and initiated the broader conversation of the impact drugs policy has on *all* drug users.

The following is an exploration of my engagement in the third LLEEG meeting. This meeting was a full day workshop organised by the PADS Executive group with the aim of

establishing a *"network of people who are experts by experience"* (Field notes, LLEEG, 2017), getting feedback on the draft drug strategy 'Seek, Keep, and Treat', and developing pathways for involving more people with lived and living experience. I have adapted my own reflections written just after the event, combined with official records of the event, and up to date reflection and analysis. Many of the quotes are taken from the official report sent out to participants. When I am using these quotes, or any part of the official report I shall use the reference LLEEG report, 2018. The report is public, but not published online.

Lived Experience Group Number 3 – 25th January 2018

We were introduced to the event and informed we would be looking at all different aspects of the addiction/recovery continuum. This made it explicit that the focus was on 'problem drug use' as opposed to all drug use. The Scottish Government aims for the refresh were to broaden the advisory structure to include service users ('problematic drug users') in order to provide:

1) Continuous improvement – which involves service user engagement.
2) Asset-based – looking at the things which are good – not just as what are bad/not working.
3) Co-produced –mobilising service users to help produce research.

The event was structured into different sections. The Minister for Health and Sport at the time - Aileen Campbell - spoke first, and then left for the day. This was not received well, with participants feeling that they were being subject to the same treatment that had been going on for years: *"[W]here are the outcomes of these meetings being carried forward? "I've been coming to these sorts of meetings for years and the Minister turns up and then she leaves. Smacks of tokenism"* (Field notes, LLEEG, 2018). Underlying this is the belief that Ministers are not actually interested in the voices of lived and living experience, which sets the tone for the engagement going forward.

In her speech to the group the Minister reiterated the tagline of 'Seek, Keep and Treat', and how this means the focus is completely on services, but she highlighted that she wanted it to be holistic, all encompassing, and trauma informed. She stated that she wanted all policy to be underpinned by lived experience input, but she was also looking to be challenged, for the boundaries to be pushed. I found this to be at odds with the discussion I had with her prior to the speech. I cannot comment on the discussion except to say she appeared to be emphatic that much of the drug policy responses were constrained by constitutional elements. I call this 'constitutional sidestepping'. By acknowledging but ignoring, a form of this tactic is successfully employed to dismiss the views of those who are not considered legitimate stakeholders in drug policy discussions.

We then did an A-Z exercise where people were asked to put comments starting with A through to Z on what recovery meant to them. This was another indication that despite remarks to the contrary, the group was focused solely on the recovery agenda.

In discussion with people during this aspect of the event it became clear that the focus on recovery and addiction silences, or completely ignores, all other forms of drug use, and users. There is a focus on addiction (or 'problem drug use') because people with addiction present the biggest 'problem' to society in regards to economic and social impact. Despite the fact that there is a recognition of the social conditions and trauma that leads to or exacerbates 'problematic drug use', the focus is firmly on the drug use of *individuals*, how can we help *'them'* stop using drugs.

A comment from the main facilitator highlighted the underlying normative assumptions of those in the recovery and institutional organisations: "*we asked not just people with lived experience but also academics, experts and professionals…"* (Field notes, LLEEG 2018,). My indignant personal agenda raised its head again. "*But I am an academic (burgeoning at least), and an 'expert', and a professional, as well as a person with lived/living experience. Where do I, and all those like me, fit into all of this?*" This narrative establishes an epistemic boundary which makes lived and living experience, and academic and professional judgement mutually exclusive. By creating these distinctions the narratives of 'us' and 'them' are maintained, and the avenues for engagement are constricted to the type of stakeholder you are identified as, or identify with.

Once again, this focus on problem drug use to the exclusion of other forms of drug use highlights where the silences are in this engagement. By limiting the possibility of discussion to people with lived and living experience of problematic drug use, and further limiting this to discussion on treatment provision and how to increase uptake, a large section of the drug using population is ignored.

Feedback on the Draft Strategy 'Seek, Keep, and Treat'

The main focus of the event was the feedback on the draft strategy document. A member of the Substance Misuse Unit (SMU) introduced the strategy, and appealed to the participants to look past the title and focus on the content. In doing so, he made it clear that they were already aware of the problems associated with the title. The following explores how the strategy was introduced to participants, and the reactions to the strategy, with analysis.

The tagline 'Seek, Keep, and Treat' came out of the Opioid Replacement Therapy (ORT) Rapid Evidence Review by the DSDC (2013), with each word representing a stream identified as being important in encouraging uptake of ORT. While the streams identified fitted an academic/policy review language, the translation of these into a strategy entitled 'Seek, Keep and

Treat' demonstrated a lack of sensitivity or understanding about how that title may come across. The following is an exploration of the response.

The SMU member urged us to look beyond the headline and try to imagine initiatives and possibilities that are not immediately obvious. He introduced them as:

1) Seek – finding those people who are not in treatment and supporting them in a compassionate way.
2) Keep – designing services that attracts people and makes them want to stay.
3) Treat – how do we keep and treat people to help them 'change'.

The group were asked to comment where we thought lived and living experience sat in this process. We were asked to discuss (i) what we thought of the wording and substance of the draft strategy, and (ii) what we thought would 'solve' 'problematic drug use'. Here is another example of the harm paradigm that drug policy is seen through. In engaging drug users in policy there is an unchallenged assumption that their use is a 'problem' to be 'solved'. This paradigm is critiqued and challenged using critical drug theory set out below.

It is fair to say that the response from the floor was not enthusiastic. The people in attendance expressed great dissatisfaction with the slogan. The (good?) intentions behind it being obscured by the language used. Discussion on the wording elicited strong responses:

- *"This is inherently stigmatising – would you do the same for obesity/smoking?"*
- *"It's really important the government gets the language right. Stigma starts in policy".*
- *"I think the heading is absolute balls".*
- *"Seek, Keep, Treat. Sounds like a zoological hunt for an endangered species".*
- *"The strong reaction is rooted in fear. There is fear that the professionalised world of academics and medics are (re)exerting their powe*r" (LLEEG report, 2018,5; Field notes, LLEEG, 2018.)

1) Seek – means you are looking for people with certain characteristics. Yes, it can be said there does exist the stereotypical, low income, most likely inter-generational drug or alcohol addiction, problems in family and community, often known to services but never or rarely engaged, but this demographic forms one example of a range of people experiencing so called 'problematic drug use', and often they are part of the system already. It therefore has the possibility to increase stigma, discrimination and marginalisation.

2) Keep – you are forcing people, or strongly encouraging people into pre-defined models of what is believed to be the 'best' treatment model. This is despite the assurances that treatment should be tailored on the needs of the individual.

3) Treat – too clinical, *"operation addiction, sounds like the name of a heat seeking missile"* (Field notes, LLEEG, 2018). The focus is still on the individual, it is the person using the drugs which is the focus of attention, not the context, the institutional and societal frameworks.

This fear is not misplaced, as has been born out by the disbanding of the LLEEG group and the replacement of an advisory structure that focusses heavily on academic and medical interventions (Drug Deaths Taskforce). The use of language was deeply misguided, and showed that those developing the policy had little understanding of the impact it would have on those the policy is directed towards. Further, participants expressed the fear that:

> *"[T]he gains of the last few years are being set aside. There was anger in the room. People feel disempowered by this. People also saw the model as being a 'rebrand' of what is currently being offered. What is being offered are not 'recovery' services. People feel that recovery hasn't been given a true chance, it hasn't got started in many places"* (LLEEG, 2018, 5).

The reason people feel this is that practice throughout Scotland is not being carried out uniformly. Access to services, how recovery is being implemented, and even what recovery means, are still issues in many areas (c.f. Dundee Drug Deaths Commission).

- *"Related to this is a feeling that no-one is being held to account, that there is no responsibility being taken by services or those with power (whether political or purchasing). There is a question that needs to be raised about the hierarchy of evidence that gets used to help shape strategy and system redesigns such as these. Who gets listened to, and why?"*
- *"It explicitly focuses on a certain demographic. BUT, when challenged we are told it is about ALL".*
- *"The clinic model has not had and continues to have very limited success. How does this wording suggest anything NEW?"*
- *"How is this different from the concept of ESSENTIAL CARE in the 2008 strategy?"* (LLEEG, 2018, 5; Field notes, LLEEG, 2018)

This links in strongly with the research into different types of evidence and the weight given to it. There is a belief that robust and strong evidence is based on scientific research principles, and that stakeholder input in the form of stories or narrative (as opposed to technical reports, scientific research and so on) are considered persuasive arguments that may support policy proposals, but not as the main body of evidence (Epstein et al, 2014; Coleman and Gotze, 2001;

Jasanoff, 1994). For example, an interview participant, who was also one of the main policy advisers to the Scottish Government, had this to say about the hierarchy of evidence:

> *"I mean look up the Cochrane database, they do surveys on analysing the evidence on this drug and that drug, this procedure that procedure, you know they'll do research on… And Cochrane databases are hugely informative and hugely useful, in just spelling out what is the literature and that's what it says. So the top of the evidence tree is RCTs, you know double-blind trials, but the bottom of the evidence trail is self-reports and opinion, either professional opinion or patient opinion. So you know if they were scoring it after 10-and they don't score out of 10- but if they were, 10 out of 10 would be an RCT on the subject, one out of 10 would be a patient saying this drug worked and now I feel better and the pain went away, and all the way in-between you have different levels of studies.*
>
> *So you know you've got observational studies or studies with patient groups, you got non-controlled studies, so there are levels of evidence, and all these levels of evidence are taken into account. So if you're studying the effect of a drug on rheumatoid arthritis you will go to the database and say where are the RCTs on this, there aren't any okay, where are the observational studies, here it is, quite a good study, you know this is a good study from France that shows 300 patients reported positive… So you know you have a level of evidence there. But you know you would like an RCT, so people would go on to do in RCT, and it is a big investment you know then people would like there to be RCTs, RCTs are considered to be important. But for policy, policy doesn't work like that… [T]hey sort of say how much damage is this going to cause me to make this decision" (*Senior Drug Advisor).

What is interesting about this statement on evidence hierarchy is that in some ways he contradicts what those in the LLEEG *feel* is happening - that the academics and medics are re-asserting their power. This participant comes from a medical background, and his use of evidence is based on that paradigm. Yet his perception is that decisions on drug policy are made on a damage limitation basis, as a further quote illustrates:

> *"I mean Michael Howard said to us (the ACMD) once, you know we said 'we need to do something on cannabis Minister', and he just laughed said 'why would I do anything on cannabis', he says 'how could that possibly help me as Home Secretary to do anything on cannabis. You find out it is not harmful is that going to help me? You find it is harmful is that going to help me?"* (Senior Drug Advisor)

These quotes illustrate that the participants have in fact good reason to be fearful and feel dis-empowered as the medico/legal/political paradigm appears to be as strong as it ever was. There were feelings in the group that the LLEEG was just another political exercise to smooth over the media coverage of the drug related deaths, and to provide evidence that they are engaging with

stakeholders, as per the Scottish Governments commitment. Indeed, during my data collection I had begun to wonder whether I should have focused a bit more on evidence, however when I put this to an interviewee responsible for evidence and data in health research she replied '*"well it doesn't exist does it! So, while there is a lot of effort being made to create evidence informed alcohol policy, drug policy does not have the same investment*" (Senior Civil Servant).

Furthermore, to many people the frustration was that ideas such as this continues to miss the point – that 'addiction' is a symptom of something else. We can continue to "*shift the deck chairs on the Titanic"* (LLEEG 2018, 5) but what is really needed is something that begins to address the reasons why people get 'addicted' in the first place: "*Why the addiction, why the pain, society broken",* and*, "most people use substances to cope with underlying issues. Until you find out what the true root of the problem is, it's like a plaster over a gaping wound"* (LLEEG, 2018, 5).

An Example of Narrative Intervention

Overwhelmingly the response to the draft strategy document was a focus on the stigmatising impact of the choice of words. Alternative wordings were suggested:

> *"Find, Choice, Offer, Nurture, Enhance, Support", "Welcome-Input-Nurture",* and*, "Options/Choice/Empower"* (LLEEG, 2018).

These alternative words show how the participants felt policy *should* be developed. Using words such as "*choice, options, empower and nurture*" shows the human rights based language that we have come to internalise through the focus on such rights: Participants want to be respected, to be given choices on how they engage with the system. In response to this criticism the SMU changed the title of the strategy to 'Rights, Respect and Recovery', and embedded peer engagement and participation into many of the key outcomes. The 2018 drug strategy states that "*all citizens:*

- Have the right to health and life - free from the harms of alcohol and drugs;
- Are treated with dignity and respect;
- Are fully supported within communities to find their own type of recovery*."*

(Scottish Government, 2018, 4)

Having gone from a medicalised 'problem' orientated response with 'Seek, Keep and Treat', the final strategy document focusses on human rights, dignity, and the role of communities. This change in language is an example of a narrative intervention: where the language was changed in order to reflect the perception that previous language was harmful to the stakeholders it was aimed at. However, as we have seen, despite changes in language, even those who have been

identified by policy makers as 'key' stakeholders express frustration at the lack of perceived meaningful engagement. An pillar of critical drug theory would use these stories of frustration and develop narratives to challenge, and change the systemic 'problem'.

In contrast, my experience of engagement between institutional actors such as the government and the police, and users/non-traditional stakeholders within the medicinal cannabis movement in Scotland was not so organised, as set out further on. The next group I look at explores how 'professional' stakeholders can navigate engagement with policy actors.

The Scottish Drugs Policy Conversations (SDPC): The Professional Stakeholders

As outlined above, SDPC was set up by co-convener Mike McCarron and myself, and initial participants were those who were known to us, and were in some way involved in drug policy deliberations in Scotland. However, the groups aims were to go further than just 'chat' about drug policy, but to have meaningful engagement and input into the formal policymaking process (see Appendix 2 for breakdown of conversations). Meaningful engagement and input for SDPC meant direct links with the bodies who formulate and implement the policy, through engagement of these bodies in the conversations. This meant that in order to us to feel we had provided both meaningful engagement and input, members of the government needed to attend (in particular the SMU) as well as other institutional bodies such as Police Scotland, NHS Health Scotland, and the different 3rd sector groups involved in carrying out drug policy initiatives. Furthermore, we wanted to see themes and discussions arising from the conversations being implemented by these organisations through language change (such as the commitment to engage more stakeholders, and a move away from terms such as 'addiction'), and a more general focus on the impact of policy, as opposed to the impact of drugs. However, because of the structure of SDPC – initially designed to be collaborative and have a focus on the quality of the engagement as opposed to outcome focussed – the concept of 'meaningful engagement and input' was more about personal experience, and therefore cannot be quantifiably measured.

This story is about how to become involved in the policy advisory framework without being part of that framework. It highlights the ease with which those who are considered 'professional' can access policy makers and the wider advisory community, despite not being part of the official framework. Once again I use a mixture of field notes at the time combined with up to date reflections to form one narrative, as well as quotes from interviewees and documentary analysis.

Negotiating Engagement: Stakeholders

The first step was to contact the Drug Policy Unit of the Scottish Government (now the Substance Misuse Unit - SMU) to make an introduction. It is not easy to get the emails of particular civil servants, and I used my networks to find out who I should be contacting. Here is a musing on the initial set up process:

> *"I have had some really good communications with several people I have approached about the SDPC. Many people are on the same page, and I realise that this process is going to need to be delicately managed, as there are so many different groups and people, ideas and motives that in a sense it can't become too solid in its aim. I think it has to remain a relatively ad hoc collaboration but provide a forum whereby different experiences, opinions, research and ideas can be shared. This should also include a mechanism to feed directly into policy, kind of acting as a third party but maybe not as that term is not a good representation"* (Reflective diary, 21st April 2015).

I am musing here on the positivity surrounding the initial setting up of SDPC. Many people I had engaged with through interviews, participant observation and informal conversations at meetings and within the drug policy community, felt that a new way of discussion and collaboration on drug policy issues was needed. There was hope that the 'new landscape' outlined in the Scottish Governments 2015 document could lead to meaningful engagement with non-traditional policy stakeholders. There was also a desire to include as many voices as possible, in the recognition that different perspectives needed to be listened to. We held our first conversation on the 18th June 2015 with 20 people attending.

Overview of SDPC 1

> *"Working within such a process, the inaugural meeting of Scottish Drug Policy Conversations served primarily to prepare the ground and build rapport between all participants. People attending showed openness and keen interest in being involved with an initiative that may help change the way in which drug policy is viewed and talked about in Scotland. Much of the conversation was about why people attended; their questions about current policy, a concern to engage all stakeholders, and other issues detailed below. There was not enough time to focus on systemic issues or discuss the pros and cons of current legislation almost fifty years on from the Misuse of Drugs Act 1971. As a result it was agreed that the same group should meet again with the aim of reaching a deeper and shared understanding to underpin a proposal for the focus, next steps and timeframe of SDPC.*
>
> ***…Conclusion and Next Steps***
>
> *There were encouraging signs that Conversation 1 created a safe space to air critical questions, personal experience and thoughts about drug policy.*

> *The ever-changing complexity, variety of stakeholders, and continuing harms associated with drugs indicates drug policy is apt for consideration using PRUDDIE (an engagement technique) and keeping in touch with other participative social change technologies being tried out in Scotland"* (SDPC 1: Record of Discussion, 18th June 2015).

Conversation 1 generated an enthusiastic discussion. The focus on the concept of respectful dialogue (see Appendix 3) and even the setup of the room (a circle as opposed to tables and chairs) created an environment that encouraged open, yet challenging dialogue. Although at times there were competing views, because of the structure and the facilitation in particular, these views were discussed in a respectful way. Additionally, on reflection, the timing was important. Scottish drug policy was beginning to experience a lot of criticism, and relationships between the different stakeholders was often confrontational. Providing this safe space to explore these sensitive issues was important, and feedback at the time and since has been that we found a window of opportunity to influence policy decisions (Kingdon, 2003). Whether we influenced policy was another matter and will be discussed below. One aspect that was not recorded in the official minutes was the reasons why people were interested in being involved. Everyone in the room was involved in different aspects of drug policy, from academic research, providing front-line services, policy making, policing and health. All those who came to this first meeting did so because they were frustrated with the pace of change, had an interest in dialogue on the issues, and importantly many had some kind of lived experience - either personal use or through friends and family - that made them view current drug policy as not working. This is a theme I identified throughout my thesis, and beyond. Those who have a personal stake in the outcome of policy, either through friends, family, or from engagement in the field for a long time, appear to have more impassioned engagement in the process, and usually directed their views towards drug policy reform.

Furthermore this meeting was attended by civil servants from the Scottish Government, who participated in the open and honest conversations generated within the group, and between the smaller group discussions. This set a tone, at the outset at least, of meaningful engagement: participants felt they were in some way involved in the process of policy making at the agenda setting stage.

These smaller group conversations highlighted systemic issues surrounding drug policy, one of which was that a focus on drug harm meant that those who use drugs without such harm were silenced and ignored, and have limited avenues of 'officially' contributing to drug policy formation:

> *"it was expressed by many that the current legislative and policy framework does not recognise the multiple ways in which drugs are used. It therefore tends to focus on problematic drug use and criminalises those who use recreationally, responsibly and to further their own personal development. Within this discussion concepts of what drug*

related harm actually means and the social impact of drug use were highlighted as problematic.
While many (not all) participants thought that reformative and even legislative change is needed, and indeed with many having been involved in shaping drug policy over the years, there appears to be difficulty in influencing policy considerations at a higher level to take account of changing attitudes of the public, research findings and shifts in drug policy and practice in other countries towards less punitive drug regulation" (SDPC 1, July 2015).

Despite the fact that the room was full of people who held prominent positions in drug policy formation, this frustration on the pace of change was almost unanimous. The question that bugged my mind was why, despite the frustration at many levels, is there not more movement? An interviewee answer may help to clarify:

"[O]f course there is a complex drug problem, with lots of other things, but I think the belief in government circles is that we're quite safe to not do anything, not get too involved, and you can quite happily cut back and nobody's going to complain. So, cynically I think there is a view that there is no need to do anything urgently, and despite colleagues and other people I know trying to draw attention to it - you know these new guidelines are going to draw attention to some of the harms, our own committee shouting about all the harms are going on (Drug Related Harm PADS Committee) I think it will have some impact. Ministers listen to it but I don't think they have the statesmanship to sort of say okay we need a shift here, we need something new, we need something different. And I don't think we have the money to do it either, you know that's a problem in a declining economy then it's very hard to find things - you know - to put some things ahead of other things. So saying you gonna spend, I don't know - an extra couple of hundred million on drug use services - because that's what it would take - people are going to say what about the waiting lists for hip operations for little ladies" (Senior Drug Advisor).

What is being said here is that despite there being serious concerns from the drug policy advisory committee, and the wider drug policy community, about the pace of change, politicians do not want to become too involved because services for drug users are not as politically sensitive as "*hip operations for little old ladies*". The fear of public retribution should money be spent on 'wicked issues[29]' prevents investment in drug services, and ultimately more deaths. Returning to the theme of 'meaningful engagement and input' this comment makes it clear that unless drug use and drug policy become as salient issue for the 'general public', such engagement and input will not take place.

[29] This term was used in private discussion with a minister when asked why the Scottish Government were not more vocal about drug policy reform. However, this term developed in the 1970's as a way of describing policy problems that are complex and difficult to deal with using simpler exhaustive solutions (c.f. Rittel, H & Webber, M. Dilemmas in a general theory of planning, Policy Sciences, 4, 155-169).

Overall this inaugural meeting highlighted master narratives that are being explored throughout this thesis: the focus on problem drug use as opposed to *all* drug use, resulting in a silencing of narratives that challenge this focus; and the desire to see more meaningful participation in drug policy formation which may help to speed up the pace of change, at all levels.

Negotiating 'Meaningful Engagement' - Policy Makers

An important element of creating 'meaningful engagement' was the involvement of the Scottish Government Substance Misuse Unit (SMU - formerly the Scottish Drug Policy Unit) - the civil servants responsible for Scottish drug policy. I had good email communication with members of the SMU, and with representatives at our initial conversations. However, our role and position within the formal policy process was not clear, and Mike and I were invited for a meeting with the Unit Manager (UM) and Division Head (DH) to discuss how SDPC could contribute and compliment the formal structure. The following is an excerpt from my notes of the meeting in January 2016:

> *"AR and MM then gave a background on SDPC and thoughts on where this may be leading – we felt that SDPC provides an amazing space for people to talk about issues without it becoming confrontational. We also saw the possibility for SDPC to collaborate with the SMU on an ad hoc basis and this was picked up by the SMU and agreed. When we outlined the core problems identified by the group in SDPC 3 we were told that the same problems had been identified in a similar exercise carried out internally within the SMU. This helped to make us all feel we are singing from the same hymn sheet, as far as problems are concerned"* (Field note, 2016)

Mike and I were greatly encouraged when we discovered that many of the themes SDPC had identified were replicated by the internal exercise at the SMU. Overall the focus was on the dynamic between health and criminal justice approaches, and evidence in policy formation. In particular, the focus on drug related harm, combined with criminal justice measures, means that harms created by drug policy, and those who take drugs without harmful side effects are ignored. Listening to those voices helps to de-stigmatise drug use by highlighting how not all drug use is harmful, and that drug users do not lack agency. Furthermore criminal sanctions, and a focus on the harmful effects of drugs perpetuates stigma towards drug users by (i) criminalising the activity and thereby creating criminals, and (ii) perpetuating the narrative that all drugs are harmful. The important point is that there appeared to be alignment of narratives between those in SDPC and the civil servants responsible for drug policy. This was furthered by the following:

> *"UM emphasised that the goal within the SMU is to reduce the harms associated with problematic drug use and this is important as it highlights the actual goal, as opposed to the implied goal which outsiders may believe exists. How we reach that goal is where the*

differences lie, and the SMU are constrained in the options open to them. Always a focus on problem drug use and associated problems. AR highlighted that part of the discussions within the SDPC had raised awareness of the non-problematic drug users, and how these represented the majority of drug users. If this is highlighted and is given more coverage it then focuses the attention on the <u>real</u> problems being suffered by problematic drug users; life history and trauma rather than drug use per se. UM and DH agreed with this."

This was the first time I had heard what the goal of Scottish drug policy is 'from the horses mouth' so to speak. While reduction of harms resulting from 'problem drug' use is a key goal of Scottish drug policy (Scottish Government, 2008, 2015, 2018) there is less clarity on how this harm is identified, and whether all forms of drug use are covered by it. Key to this was the agreement that the drivers of problematic drug use must be addressed, and this was evident in the future 2018 drug strategy Rights, Respect and Recovery (Scottish Government, 2018) (chapter 6 and 7) which focussed a large portion of the strategy on community recovery and addressing underlying problems such as mental health and early life experiences. This exchanged clarified that the goal was the small minority of drug users who had multiple problems including drug use – the 'problematic substance users'. Furthermore, it highlighted that it is not only non-institutional stakeholders that need to be meaningfully engaged. Participation of civil servants, and the involvement of *all* stakeholders is required in order to create meaningful connections and dialogue. The agreement from the SMU that most people use drugs non-problematically, and that by focusing on this we can move attention to the *reasons* people use drugs, as opposed to focusing on *people* who use drugs, was important, and signalled the common counter narrative to 'problem' drug use that was emerging from this engagement: that the focus on 'problem' drug use ignores/silences non-problematic drug use.

Other notes of this meeting included:

"The SMU seemed encouraged by the direction the SDPC appears to be going and we then discussed exactly where they thought the SDPC could contribute. It was suggested by us that we would continue to work as an independent group but could potentially provide an advisory role on specific items. It was also suggested, by the SMU, that the SDPC could help to smooth the way for certain policies which may receive backlash from the media. Although no specific policies were mentioned in this context it was said that when a minister starts his/her position s/he is presented with a range of policies by the SMU, which includes other possibilities, but until there is clear public support for such initiatives these policies recommendations remain under the table.
In the final part Mike and I clarified that the SMU would encourage the continuation of SDPC in whatever role, including challenging the status quo and having a reform agenda. We ended with an agreement that a representative from the SMU would always try to come along to the sessions in order to continue the link, and that Mike and I would start the

process of incorporating the structure of SDPC with a view to becoming a part of the wider Scottish drug policy landscape. There was a suggestion that Mike and I meet with the SMU quarterly to update and see whether there are areas we can collaborate on."

This final section shows that the initial engagement with the SMU was productive, and there was agreement going forward of both the role of SDPC in providing the more challenging/reform agenda style input, and the engagement of the Unit in the meetings. This engagement of the Unit provided the first step towards what we had identified we would need to provide the *perception* of meaningful engagement and input. Given how our collaboration actually worked, this initial meeting appears to have been more aspirational than was perhaps achievable. If I had known about the comings and goings of the independent Drug Strategy and Delivery Commission (chapter 6) I may have been more wary. However, here it shows how negotiating engagement with policy makers involves reciprocal arrangements. We agreed to help them by smoothing the way for potentially controversial initiatives, and they helped us by agreeing to attend the meetings and continue the dialogue. This worked for us because it was important that SDPC had some formal arrangement with the SMU in order to give a sense of legitimacy and ability to enact change. On the other hand it worked for the SMU because it showed they were engaging a broader range of stakeholders. We were, in effect, working within the horizontal policy making arena (Colebatch, 2009).

The creation of SDPC provides an insight into how non-traditional structures can participate in the policy arena, yet we were taken seriously because our participants were viewed as 'legitimate' and the way in which we engaged was non-confrontational, to be begin with. Our participants were pooled from a cross section of stakeholders and included many of the 'same old faces'. Yet there were many non-traditional participants such as the Psychedelic Society of Edinburgh, cannabis reform campaigners, criminal justice reform groups, 3rd sector organizations that were not currently involved in policy, and a range of academics. This gave us an additional appeal: not only were we conducting our conversations using deliberative public engagement processes with a focus on respectful dialogue, we had managed to gather a varied mix of stakeholders. As the co-convener of SDPC, which was being hosted at the Institute for Governance at the University of Edinburgh, and a PhD candidate with professional experience in the public sector, I was able to approach senior figures in a range of institutional settings and be taken seriously. My own drug using history was not known, and I was therefore considered a neutral broker between stakeholders. Generally speaking I had little difficulty accessing policy makers and associated advisers, and developed professional relationships with members of the SMU. This enabled me to feed back the outcomes of the SDPC, in the hope they would be used to help shape policy. Maintaining this relationship was more challenging.

The next section explores the deterioration of my relationship with institutional actors as my persona of neutral professional/expert became entangled with activist based stakeholder persona (the sick and/or happy drug user).

Medicinal Cannabis Reform Scotland (MCRS): The Sick Stakeholders

There are two kinds of 'sick' stakeholders: those who are considered sick as a result of their addiction and are thus legitimate participants in the policy process, and those who are using illegal drugs to treat illnesses as a result of a disease like cancer, epilepsy, fibromyalgia, anxiety and so on. This research shows that the latter stakeholders are not considered legitimate by institutions such as government or the police, at least not legitimate enough to be involved in policy decision making.

This case study follows my engagement in the Medicinal Cannabis Reform Scotland (MCRS) campaign, as they attempted to create some form of stakeholder engagement with the Scottish Government on cannabis issues. MCRS is a grass roots campaign calling for the 'Right to Choose' medicinal cannabis to treat illnesses – the concept of individual sovereignty and the empowerment of stakeholders to treat themselves in the way they see fit (Appendix 4). I use field notes, up to date reflection on the process (as a form of auto-ethnography), and minutes of the meetings. For the most part I combine field notes and reflections into one, and present as the following narrative.

I became involved with the campaign leader through liking a Facebook page set up to support the first meeting held by MCRS at the Scottish Parliament. They had managed to get several MSP's and other interested parties to a meeting to discuss the movement towards a medicinal cannabis framework in Scotland, and I was impressed. I contacted them and suggested they became involved in SDPC, and she attended the SDPC session on Cannabis (Appendix 2). However, it became apparent that the best role for them was running the MCRS group and building momentum for that campaign. They set up the first meeting and I helped them set up the subsequent ones by connecting them with relevant institutional actors such as the SMU, Police Scotland and the Crown Office and Procurator Fiscal Service (COPFS). My role within this process has been to provide the academic position, to highlight the legal and practical hurdles that need to be overcome, and to provide a link between the different stakeholders involved by chairing the meetings using SDPC principles of respectful dialogue. In addition I identify as a cannabis user, both therapeutic (I use for helping to sleep and as a topical cream for eczema) and recreational. This meant my persona in this process straddled both the professional, the happy and the sick drug user.

The campaign is heavily focused on medicinal cannabis, and therefore follows a narrative of people who are ill and need to be able to access their medicines. It was set up by a woman who

suffers from multiple conditions, the most debilitating being fibromyalgia, and uses cannabis to treat them. She works alongside the stalwart mother of an epileptic boy who has been a tireless media campaigner, putting pressure on the policy makers from a different angle (Blackstock, 2019). Lisa's son has gone from up to 100 epileptic seizures a day to zero in the last year and a half since using legally prescribed Dutch cannabis oil. The problem for her and other patients is NHS Scotland won't fund legal cannabis prescriptions, and the Scottish Government, so far, have been unwilling to step in to provide guidelines or funding. The sick consumer is popular at the moment because it highlights the need to focus on health rather than criminal approaches to drug use. Cannabis, as we know, has developed a strong narrative of medical/therapeutic use, and is legal in several countries already. Yet there is a blurred line as to what constitutes medicinal or recreational, and this is what concerns the Scottish Government, the police and other institutions and individuals who see injection of substances for pleasure as wrong or indulgent.

This group engagement highlights one narrative of the 'sick' stakeholders: those who have illnesses that can be treated using (illegal) drugs. The focus was on dialogue around the policing of people who use cannabis for medicinal purposes, de-facto decriminalisation which is within the competence of the Scottish institutions needed to implement such a measure: the Scottish Government, Police Scotland, and the Crown Office and Procurator Fiscals Service (COPFS). Most importantly they wanted dialogue, to feel like their concerns were being listened, to, and hopefully acted upon in some way. While the sick stakeholder is a legitimate participant in the 'recovered' stakeholder narrative as a result of the addiction as a disease model (explained below), the sick stakeholder who does not suffer from addiction is not afforded the same privileges.

From 'Notes on MCRS - October 2017 to December 2018'

The following is data taken from my notes of engagement during this period. I combine the notes written during this time with more recent reflection, turning the following section into a narrative of engagement.

<u>Initial engagement</u>

One of the main stumbling blocks in moving MCRS forward was getting the SMU, and in particular the Unit Manager (UM), to engage with it. I was informed during a private conversation with the SMU that cannabis is not an area of importance to either the government, or the police. I was also informed that there was concern about the focus. The UM, and by extension the government ministers, were wary of being 'soft' on cannabis and not highlighting the dangers of excessive cannabis use. However, the Scottish Government stated that they were open to the implementation of medical cannabis, and there was a suggestion that I use the SDPC as a vehicle for dialogue. I began to set one up, but I was not able to 'control' the lines of communication

between BM (the campaign manager), and the various institutional bodies she was contacting. And nor should I, but this lack of control, and the passionate and at times aggressive way that BM approached institutions, meant I was often on the back foot in regards persuading risk averse civil servants to engage. As a result, the following exchange took place.

BM had been trying to engage the Scottish Government for months, but all she received was the stock replies stating cannabis is a reserved matter and until this changes the SMU will not enter into dialogue with stakeholders – an example of 'constitutional side-stepping. However, once I became involved I contacted the SMU to request attendance, and in response BM received communication that someone from the SMU would attend the meeting. This was good news and a signal that, as per the motion passed at the SNP conference in November 2016 on implementing medicinal cannabis in Scotland, the Scottish Government were taking the stakeholder involvement seriously. Yet it also showed that these stakeholders were not being taken seriously until a 'legitimate' stakeholder became involved. In this case I was the 'legitimate' stakeholder, and my legitimacy had been built up as a result of my previous engagements with the SMU around broader drug policy engagement, and my professional/academic persona. In the build up to this meeting I had several phone conversations with the UM in which it became apparent that the only reason the Unit were considering engagement was because of my involvement as a representative from the SDPC.

However, this changed. The UM declined the invite without saying why, and this decline sparked BM to lodge a formal complaint with the Scottish Government, in particular the SMU and the then Unit Manager. I found myself scrabbling to provide damage limitation and restore relations between the SMU and BM. The complaint was made on the basis that the SMU had a duty to engage with cannabis stakeholders, and the refusal to attend the meeting was a dereliction of duty. The reason I was given for the refusal to attend was more mundane: the UM was not working that day and had a prior commitment. It was argued by BM and MCRS representatives that the UM could have delegated attendance to someone in the SMU, as is often the case for stakeholder meetings, and I agreed. While the pulling out of attending the meeting may not have been intended as a snub, or a deliberate attempt to 'organise out' a group of stakeholders, it was perceived as such, and therefore the reputational damage was done. I was beginning to understand that engagement in the policy processes rests as much on good relations with those responsible for the formation of policy (the vertical dimension of policy), as it does on your position within the field (the horizontal dimension of policy).

The main complaint from the UM regarding the MCRS was that they did not follow the correct protocols in setting the meeting up, and that there was too much emotion and aggressive energy being directed at the Scottish Government. This speaks to concept that policy involves order "*that is, shared understanding about how the various participants will act in particular circumstances*" (Colebatch, 2009, 116). The meeting had been termed an All Party Parliamentary Group (APPG) yet in reality it was not. APPG's must follow certain protocols and this had not

been done. The meeting was being hosted by the Scottish Liberal Democrat Alex Cole-Hamilton's office, and this was another alleged barrier to engagement. I was told that it is unusual for civil servants to attend meetings hosted by opposition parties, but I have since learned that this is not the case. It was suggested that SDPC become the vehicle through which the collaboration between the stakeholders and the government – a suggestion which was reiterated by the NHS Scotland rep, who also declined the invitation. This whole scenario highlights the difficulty in creating policy engagement outwith the recognised norms of policy making, and the difficulty institutions have in extending their vertical dimension of policy development, to incorporate broader horizontal ways of engaging.

The other institutional actor that was missing was Police Scotland. The main contact at the time had accepted the invitation, however following the formal complaint and the subsequent fall out, the invitation was also declined. There was a feeling in the MCRS that the Police Scotland and NHS Health had pulled out under pressure from the UM in response to the formal complaint. This feeling exacerbated the alienation felt by those in the group, and the feeling that their engagement as stakeholders was not considered legitimate by these institutions.

At this stage I was disappointed with the level of engagement by the SMU and Police Scotland, given my positive experience of engagement in regards SDPC. Despite this we received good media coverage on the various meetings, which raised the profile of the group as a whole (Nutt, 2017).

And we try again

One year later a second meeting was set up, with a vastly different outcome. Once again a meeting was called in the Scottish Parliament, and a range of stakeholders had been approached. BM and I had spent the previous year having one to one meetings with institutional actors, holding public meetings, getting sympathetic pieces in the press, and crucially the UM whom the official complaint had been made against was off on sick leave and there was a new interim manager in place. I had met with him and explained the back story, and his view was the SMU should be engaging more with the cannabis community. He responded positively to BM and they began direct communication.

The meeting's aim was to tell the stories of stakeholders who represented a cross section of medicinal cannabis users in order to highlight the different ways cannabis is being used, and the impact that the lack of regulation and continued criminal sanctions has on these stakeholders. The meeting was a success: the SMU responded positively and agreed to start investigating ways to help access cannabis based medicines, in addition to creating a more formalised cannabis advisory group. A further meeting was scheduled for 3 months time to discuss more concrete ways of getting

collaboration between the different stakeholders. Both the SMU and Police Scotland responded positively:

> *"Scottish Government: [The UM] took the opportunity to thank the stakeholders for their powerful stories, that he was touched by them, and that the Scottish Government were committed to working with stakeholders going forward.*
> *Police Scotland: Police Scotland were also touched by the stories, and respected what the stakeholders were saying. They are only human, and as it is becoming more apparent, cannabis obviously works for some people. They too are committed to working with stakeholders and those responsible for policy implementation to see that we can move forward on this issue"* (Record of Discussion, MCRS, 18th September 2018).

This use of stories to persuade policy makers of the importance of the issue being discussed is not a new tool, and is often very effective (Davidson, 2017; Epstein, 2014; Stone, 2002, ch.6). Stories help to create empathy by personalizing what is otherwise a de-personalized policy. Civil servants are used to making policy decisions that encompass a variety of stakeholders, and stories can be a powerful way of highlighting what different stakeholders feel. For example, during my interview with a Senior Civil Servant previously responsible for the SMU, she commented:

> *"[S]o, you know, I did quite like going to speak to people who were in there – called service users but actually just people – I'd like to speak to people and get a sense of what it felt like for them, and their perspective, and I did things like the LEAP programme used to do, graduation ceremonies for people coming out of that, and I did some of the graduation ceremonies, which kind of really brought home to you some of the…you know it wasn't just drugs, it was drugs and alcohol kind of related issues, but the impact it had on families. And you know the stories of the individuals that they gave at those graduation ceremonies, I mean really I could tell you the whole story because they were just so difficult to hear really, the story of their lives, and their families lives, had - I'd be honest - had really been destroyed. And you could see it in the pain in their families faces*" (Senior Civil Servant).

The result of this interaction was an increased passion to implement the 2008 drug strategy properly. What we hoped by telling the stories of those affected by cannabis criminalisation was the same. And it worked. Both the Police Scotland reps and the SMU manager left that meeting promising to help us move the issue forward. This is not the end of the MCRS story, I am still involved as a peer negotiator, and more recently we were instrumental in setting up the Cross Party Group on Medical Cannabis in Scotland (Lambrou, 2020a). There have been successes in getting prominent figures to the table such as the Chief Medical Officer for Scotland, but so far the actual requests of the group have been largely ignored. (Lambrou, 2020b).

MCRS Cross party group meeting

From left to right:

Labour MSP Pauline McNeil

Chief Pharmacist Rosemary Parr

Chief Medical Officer Catherine Calderwood

MCRS campaign leader Bernie McCreadie

Scottish Greens MSP Alison Johnson

Anna Ross

Lisa Quarrel

SNP MSP Rona McKay

Centre: UNISON Edinburgh branch Chair Tam Waterson.

Photo credit – some parliamentarian

Analysis of Narratives using WPR Approach

We have established in Part Two that the 'problem' of drugs is represented to be the perceived harms resulting from 'problematic drug use' (WPR #1). We have further established that 'problematic drug use' is the demographic of consumers who experience perceived harms such as health harms (HIV/AIDS, BBV's, and other medical conditions), combined with broader societal 'harms' such as deprivation, trauma, and mental health issues. As has been shown, the presuppositions that underlie this representation (WPR #2) in relation to participation in policy is that (i) drug use is harmful therefore (ii) participation in policy is of stakeholders who have experienced this harm and are seeking to reduce it (the sick or recovered stakeholder). This representation is not unique to Scotland, however, as Part Two shows, in the Scottish context this representation came about by a focus on certain demographics resulting from the HIV crisis of the 1980's, and subsequent policy responses to an increase in drug related deaths.

The questions this chapter sought to explore in relation to participation in drug policy are questions 4, 5 and 6 of the WPR Approach, and we shall take each one in turn.

4. What is left unproblematic by this representation, where are the silences?

The focus on 'problem' drug use has resulted in a focus on certain kinds of drug consumption, and a policy strategy to match that - recovery. As a result, only certain stakeholder views are taken into consideration when participation is being designed at an institutional level, and only certain discourse is considered legitimate. As seen above I separated these stakeholder engagements into three narratives: the professional, the sick and the recovered stakeholders. A further narrative – the happy drug user – emerged from my analysis as being absent from any of the engagements. Within these typologies, further analysis of the perceived legitimacy of these stakeholders has been done. The legitimacy of the stakeholder determines the level of 'meaningful participation': the amount of engagement and involvement in the policy process individuals are given depending on their perceived legitimacy.

5. What effects – discursive and lived, are produced by this focus on problem drug use?

As a result of policy being focused on drug related harm, participation in policy is restricted to certain channels where the government feel they can be most effective. It is evident that they feel they can be most effective in addressing the harms stemming from addiction/dependency, and participatory processes to engage this affected community are developed along these lines.

This organising in and out of decision making processes is a recognised aspect of policy making (Colebatch, 2002, ch.4; Stone, ch.15). Colebatch (2002) comments that: *authority, then, frames the action, in ways that make it easier for some people, and more difficult for others, to take part in the process.*"(27). This framing is part of the horizontal and vertical dimensions of policy making, as seen in diagram 6 below. The vertical dimension is concerned with the authoritative aspects of policymaking – the following of rules and authorized decision-making. It shows that in policy decisions there is often a line of legitimate authority, with (in the case of drugs policy) a minister as the top decision maker, and the various subordinate civil servants authorised to enact decisions.

The horizontal dimension on the other hand, according to Colebatch (2002), views policy as "*the structuring of action*" (23). It shows that policy involves multiple actors, agencies and participants that do not have lines of authority, yet are part of the policy process. They bring different ideas of what policy is to them, and how these ideas and engagements are enacted from the basis of horizontal policy making (Colebatch, 2002, ch.3). It is therefore better to think of policy making as a collection of people participating in policy through the different channels available, rather than one single set of policy makers as such (Colebatch, 2002, ch.3).

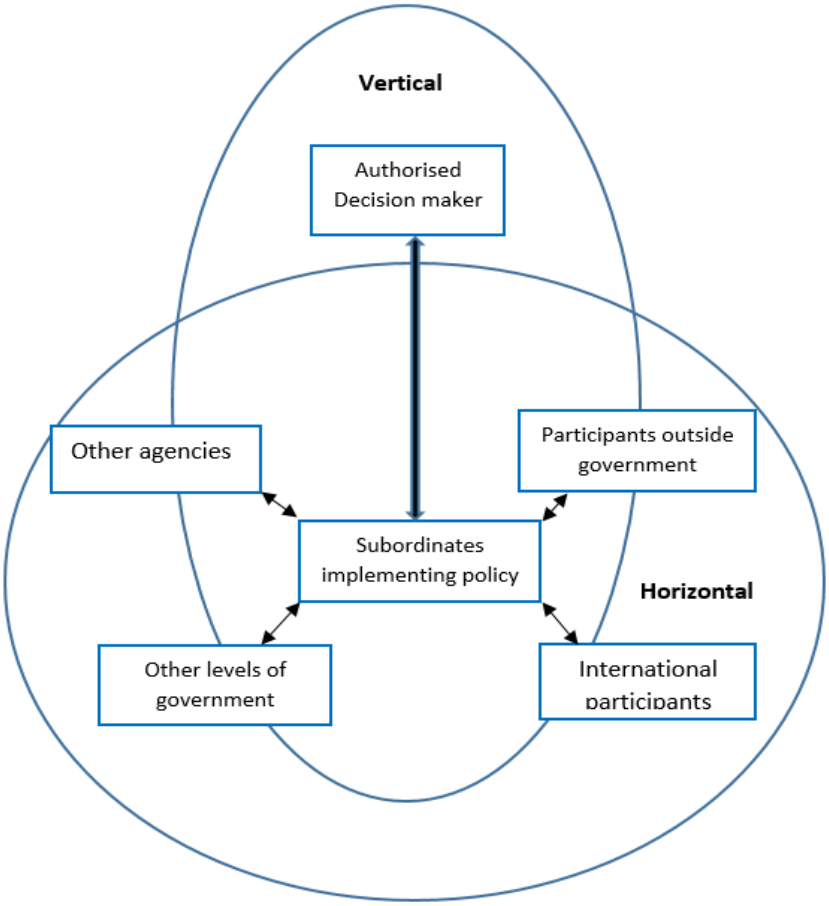


Diagram 6. The Vertical and Horizontal Dimensions of Policy. Image recreated from Colebatch, 2002, 24.

6.How can the representation of the problem be disrupted/questioned/challenged/replaced?

The main bulk of this is answered in chapter 8; however, we can see from the narrative intervention in the LLEEG group that there are areas that can be challenged, even within the current institutional frameworks. By challenging the use of language and the involvement of different stakeholders, gradually change can happen. This form of challenge can be classed as a 'narrative intervention' (Fleetwood, 2016).

The following sets out in more depth the different types of stakeholders identified by using the WPR approach, and levels of meaningful engagement afforded depending on the perceived legitimacy by the institutions of the stakeholders. This also highlights the master, counter and competing narratives. As discussed above, these typologies emerged from the data as a way to make sense of the different levels of legitimacy afforded to stakeholders when engaging in drug policy deliberations. However, categories are not fixed in their meanings, and in some ways I have simplified these types of stakeholders in order to fit them into my 'types'. On the otherhand, they

emerged from the data, and therefore represent an analysis that I saw to be correct, taking into account the interpretive nature of this research.

The Recovered/Recovering Drug Users: Legitimate stakeholders and part of the master narrative

These users are people who are either in the recovery treatment system, or have recovered and are 'drug free'. People in this community are predominantly in recovery from opiates, alcohol and cocaine, although the term covers all behaviours considered to cause dependence[30]. They are the main staple of drug policy engagement and are considered important stakeholders in policy development.

The recovery narrative has been part of Scottish drug policy since the 2008 'Road to Recovery' strategy, and this has informed much of the participation work going forward. However, as one senior civil servant responsible for drug policy at the time (2008) commented:

> *"I think the other thing that was interesting to me, and hadn't really been so…[I] hadn't really had to think about it, was the number of people involved in this world that had actually been impacted by those issues themselves. So quite a lot of people declaring early on to me that they were in recovery and it became like a…it was almost like they were more worthy than other people because of their lived experience*" (Senior Civil Servant).

I experienced the same when engaging, particularly with the LLEEG group. The legitimate drug consumer was one who had stopped using drugs and was now able to present their experience to the group. They used their experiences (sometimes from 20 years ago) as their identity within the groups, yet challenged those of us who attempted to broaden out the narrative to include different kinds of drug users. As we saw, the lived experience expanded to include living experience, yet I only came across a handful of people within the group who identified with the living element, and those who did were either parents of children currently using drugs 'problematically', or were topping up their legal prescription with street drugs.

Drug user voices have traditionally been absent in policy decisions that affect their lives (Storbjork, 2012). They are often "*treated as second rate citizens; not as subjects with rights, a voice and an identity, but rather as passive recipients or subjects of help or measures of control, punishment and discipline"* (Anker et al, 2006, 5 – quoted in Storbjork, 2012, 606). As discussed above, the development of the LLEEG group was an attempt to address this lack of user involvement in policy, and in some respects it was successful. However, while there was a space provided for those with lived and living experience to discuss and input into policy, what emerged from the analysis of this engagement was that the avenues for agenda setting were still constrained

[30] one of my interviewees identified as being in recovery from an eating disorder

to an identified stakeholder – the person in recovery. The result is a side-lining of those not in 'active recovery', and the continuation of stigma directed towards people who use drugs.

Stigma is a major theme within the drug policy community, and has become the focus of much of the institutional output. The definition being used by the LLEEG is the definition of stigma allegedly set out by Goffman "*Stigma is the situation of the individual who is disqualified from full social acceptance*" (Goffman, 1963)[31].

The stigmatisation of people who use drugs is common amongst the 'general public' as well as policy and health settings (c.f. Corrigan et al, 2009, Lloyd, 2013; Radcliff and Stevens, 2008; Room, 2005, UKDPC, 2010, 2011). A narrative literature review conducted by Lloyd in 2013 found that:

> *"Stigmatizing attitudes towards problem drug users (PDUs) are common among the general public and non-specialist professionals. The impact on users is profound and represents a significant barrier to recovery. Reasons for this extreme stigmatization include negative reactions to injecting and widespread attributions concerning danger and blame"* (Lloyd, 2013, 85).

However, there is also evidence that there is 'within-group' stigma directed to different kinds of drug users, where some are considered more 'problematic' than others (c.f. Lloyd, 2013; Simmonds & Coomber, 2009, Lancaster, 2014). This supports the experience described above, where those in recovery were engaged *because* of their recovery, and those still actively using were side-lined.

Stone (2005) notes that every part of society, every rule, policy and form of governance identifies people according to their perceivable conduct and circumstances, then sets them into categories and determines how they are to be treated (ch.2). Similarly, Colebatch identifies this 'organising in/out within policy making as an aspect of how policy formation is conducted (2002, ch.3). Individuals and institutions are identified through the policy process as having a stake in the development. However, while this may be true for 'problematic drug users' as a result of their behaviour and engagement with services that highlights their 'problems' to those around them, it is unclear what impact this has on other drug users, who may only use within a certain social group, settings, or in the privacy of their own home and therefore remain 'undetected'. Do they internalise this stigma? And if so do they then set themselves apart without the need for external socially imposed stigma, or do they internalise the stigma and reject it? These were questions that ran through my head as I engaged in the different policy meetings. The answer for me is I internalised the stigma of being a 'recreational' drug user (I am weaker, prone to self-indulgence, not a

[31] I use the term 'allegedly' because I have been unable to access the Goffman book due to the library being closed, and this quote is not fully referenced in the notes of the meeting.

'responsible adult etc. etc.). However, as a result of having to disclose my various experiences of drug use (ranging from problematic to therapeutic), I found myself legitimised in certain contexts - the family member of an opiate user, the professional with 'expert' knowledge on drug using communities, and so on.

As can be seen from the engagement above, this organising in/out of participation in policy is not only conducted by 'gate-keepers' such as civil servants, but by the very community the policy is trying to engage with. However, the side-lining of active drug users is not so clear cut, certain active drug users are afforded an element of legitimacy if they are considered 'sick'.

The Sick Drug Users: Sometimes a legitimate stakeholder

There are two kinds of 'sick' stakeholders: those who are considered 'sick' as a result of their 'problematic drug use', and those who are 'sick' as a result of a physical or mental condition not connected to 'problematic drug use'. I encountered and engaged with both groups and from this developed the understanding of which group was afforded more access, and therefore more legitimacy in the policy engagement process.

The sick user in the participation of drug policy is only fully legitimate in one context: the engagement of 'problematic drug users'. In this context the sick user is one who is currently using drugs 'problematically' and may not want to stop, but needs to be engaged in order to provide pathways for recovery when they *do* want it. In many areas drug dependency is considered a disease of the mind, and people with dependencies are considered to have a 'Drug Use Disorder' (Grant et al, 2016). The narrative goes 'they are sick and need our help to get better' (into treatment and off drugs). However, despite being a legitimate stakeholder, as seen above, those who are currently using drugs (living experience) are largely absent from the policy process (Lancaster & Ritter, 2018; Field notes, participant observation). Drug user organisations are often invited to 'represent' these voices, but*, [w]hile drug user organization representatives are usually invited to sit on committees or participate in policy events (such as roundtables), tokenism is rife* (Lancaster & Ritter, 2018, 353).

It appears that the stigma directed towards those who are currently using drugs is prevalent even within spaces that are designed to promote their engagement. While there are challenges of involving people who are using 'problematically': for example 'problem users' may turn up to events under the influence of drugs, or miss events because their life is chaotic and they do not remember (all comments given to me as reasons why it was difficult to include living experience at various events). However, these behaviours are at the extreme end of drug use, and not representative of the majority of drugs users, including so called 'problem drug users'. The main stumbling blocks are issues that can be addressed. For example, Greer et al (2016) conducted a study on peer engagement in harm reduction strategy development, and found that things such as

providing a supportive environment, equitable participation, capacity building and providing opportunities for empowerment, were vital in creating and sustaining drug user involvement. Further barriers to participation include lack of payment for attendance (Sandhu, 2017) and childcare provision (What Works Scotland, 2017; Blake et al, 2008).

However, in a different context the sick user has even less legitimacy. In the context of using cannabis, psychedelics or MDMA, all drugs that have recently been shown to help in various physical and mental illnesses[32], users are not engaged with pro-actively, and in many cases engagement is made intentionally difficult. My experience of trying to engage policy makers and institutions responsible for patient engagement such as the MCRS was difficult when I was representing the medicinal cannabis user. Indeed, my involvement with this group, as seen above, resulted in my own legitimacy being questioned, and my persona of professional and objective policy expert became one of drug user lobbyist. As a result, my ability to access institutional policy makers and engagements was reduced. The thing I am still unable to fully comprehend is whether this loss of legitimacy was a result of the personal dynamics between the different stakeholders, or a broader stigma attached to those who are pushing for engagement on these kinds of drugs. I imagine it is a bit of both, and I explore my positionality within the research context in more depth in the conclusion. As discussed above, drug users are subject to labels that once attached, are virtually impossible to get rid of. Cannabis is gradually becoming an accepted drug, however, in regards legitimacy in the policy process, it appears there is still some way to go. Having said that, as I expand on in the conclusion, since I finished my data collection I have continued to be involved in this movement, and we are starting to see meaningful engagement from both the politicians and the civil servants.

Despite this, on a wider level, the 'sick' drug user, seeking to heal that sickness through the use of cannabis, psychedelics, MDMA or Ketamine, is not present at any stage of the Scottish policy process, and would not be considered a legitimate stakeholder in the current framing of policy engagement. This is the silence.

The Professional Drug User: Sometimes a legitimate stakeholder

The professional drug user is hard to find because of the stigma associated with drug use. In general, professionals (and by this I mean individuals who are part of an institutional profession such as academia, third sector, public bodies etc, or are in the process of creating a professional career) do not disclose drug use because to do so would risk their career development. A good illustration of the consequences of drug use being discovered is the following story from one of my interviewees:

[32] See further Drug Science at: https://drugscience.org.uk/., the Beckley Foundation at: https://beckleyfoundation.org/ , and MAPS at: https://maps.org/

"An incident happened and a doctor overdosed on heroin in this hospital, and it was really horrible because it was one of these things where his wife phoned up and said my husband's not come home, does anyone know where he is, that kind of thing, and he was found in a toilet. He was alive! And of course, somehow these things always seem to get on the front page of the Daily Record you know [laughs] so names, people get named and all that. So it was one of these organisational things that happened, 'oh my god', you know. And the organisation just decided they were gonnae have this guy for breakfast, so they were gonnea take him down a very very unpleasant disciplinary route.
And as the local addictions specialist I was asked to give my opinion with regard to this guy. And of course I gave the opinion which was he has a…without going into all the details there were many reasons why this had happened, it was all very understandable, it was all very explainable. And, when you're faced with people not being able to perform at work, in the NHS, you take them down one of two routes: its' either a disciplinary route, or it's a - as we would call it- a sick doctor route. I advised we should take him down the sick doctor route.
Wow. Light the torch paper, stand well back. I was in hearings, and it was…so they were trying to say you can't possibly be a doctor and have ***had*** *a drug problem. So, because people can't…what they were really saying was people can't* ***not*** *have a drug problem anymore, he's a heroin addict, he's going to take people's drugs and use them for himself…that monster! So, it was really interesting cause I had to put…you know it was one of those, you know, when you've got a career, you actually have to go hmmmm, okay, I'm gonna step over here now, and you have to go nut (no), this is my position, here's my position"* (Drug Policy Advisor).

This story gives us insight into the professional implications of drug use, and the responses from the institution. What the narrator is telling us is that the institution was not able to respond in a compassionate way, because they did not understand the complexity of drug use. Even with the advice of the specialist, they were unable to comprehend how someone could continue to be a professional once they have used drugs. While the potential for him to be considered a 'sick' doctor (legitimate) existed, this was not an option because of the publicity surrounding the case: the fear of media scrutiny prevented the advised form of disciplinary action. This highlights the institutional oppression and stigma that I expand on in the development of critical drug theory below. There was a choice, one of which would not have involved professional ruin for the drug user. From this, and many other anecdotes I came across, it has become apparent that there is a dichotomy between the professional and the drug user (as seen by the quote in the LLEEG group in regards who was invited). It is not possible, in many context, to be both a professional and a drug user.

Research surrounding this area supports this. As discussed earlier, there is a growing body of research into engagement of drug users in policy development, but the interesting aspect of this

research is that it strengthens the argument that there is a dichotomy between an 'expert' and a 'drug user'. It is possible to be an expert with lived experience, for example Duke and Thom (2014) note that there '*has been the call for a broader notion of knowledge - knowledge based policy and practice, which includes the experiential knowledge of practitioners and the lived experience of service users"* (965; c.f. Glasby & Beresford, 2006). Furthermore, Lancaster et al (2018) notes that while there is increasing participation within drug policy development, it is limited to certain areas such as engagement on health issues (c.f. Bryant et al, 2008; Treloar, Fraser, & valentine, 2007; Treloar et al, 2011), or treatment decisions. *"Rarely are people who use drugs (or, even more so, people who deal or supply drugs) seen as legitimate stakeholders in policy discussions"* (Lancaster et al, 2018, 354). More rarely, if at all, are drug users seen as professional experts.

I experienced this dichotomy, and I believe I have gone some way to challenging it. My involvement in the policy process came about through SDPC, and my persona, as mentioned above, was one of an academic and professional. However, through the course of the engagements I became more vocal about my own drug use, thereby mixing my engagement as a professional and a drug user. The first time I informed a member of the Unit that I used drugs I was met with that slightly startled flickering eye movement. I could see them processing this information and trying to make it match with their previous impression of me. It was a risky move, and I was advised against by several peers, but I felt I could not continue to engage and speak about drug users as if they were somehow 'other' to me. My relationship with the Unit and other institutional representatives did not change much initially after my disclosure, but I was still constrained in how I could participate, through the avenues described above. I have found that the policy identity that is being cultivated as a result of disclosing lived experience, is a 'lived experience policy expert', both of whom are legitimate in my typology of participation. However, if I start engaging with the 'happy drug user' persona, I am not afforded the same weight in policy discussions.

These stories show that in some contexts the professional drug user is considered a legitimate participant, however in general professionals who use drug are not considered legitimate stakeholders in the process, or indeed legitimate professionals, in many instances.

The Happy Drug User: Never a legitimate stakeholder, and part of the counter narrative

I use the term flippantly, and to make a point, but the 'happy drug user' is the person who takes drugs and is happy, or content with their level of drug use, or just not 'problematic'. The happy drug user is hardly seen in drug policy. The idea that someone takes drugs happily, and continues to be happy despite drug use, is not spoken about, and those who do are silenced or ignored. This silencing is subtle. Because of the focus on harm, all initiatives, meetings, engagements and documents come from this paradigm. Discussions on the pleasure of drugs are silenced by the focus on harm, and those who challenge this are considered to be indulging in personal agendas.

This silence is not only notable in institutional drug policy discussions such as the government, the police, health etc., but in drug policy research and academia too. Yes, there is research into drugs and pleasure, for example in 2008 the esteemed International Journal of Drug Policy dedicate an issue to the topic of pleasure, many of the articles I will reference in this thesis. However, this is an outlier, a golden nugget for those of us keen explore more the what, why and how of incorporating pleasure into decisions within drug policy governance. The silence of pleasure discourse within drug policy research has been explored by scholars such as Kane Race (2017), who, in arguing that drug policy researchers should be thinking *with* pleasure when they explore the topic, states that despite there being some investigations into pleasure and drug policy:

> *"Researchers tend to think about pleasure or against it; we analyse, consider, investigate, invoke or ignore it. The philosophically inclined may even think of pleasure, or write on it. But in each of these scenarios pleasure is kept at arm's length and the researcher appears to remain unmoved - detached observers, objective scientists, conceptual experts, program directors, policy advocates, sharp critics - sober judges all, our sovereignty secured by the formal conventions of established theory, positivist research, institutional authority"* (Race, 2017, 245).

By keeping pleasure at arm's length, researchers disassociate themselves from the research subject, even if the researcher has some experience of the pleasure of taking drugs. This tension is explored in a paper I have written with several other scholars on the pros and cons of coming out about one's own drug use in drug policy research (Ross et al, 2020). While we do not 'come out' ourselves, we discuss the reasons why some researchers may, or may not be open about their own drug use. An important element of not disclosing drug use, or the pleasure associated with it, is the criminality of using drugs (as discussed above) and that, as Moore highlights *"writing about pleasure does not earn a researcher much in the way of research capital, so it is professionally safer to accept the focus on risks and harms*" (Moore, 2008, 355).

Other scholars such as Fiona Measham and Karenza Moore have written on the pleasure associated with certain drug such as ketamine (Moore and Measham, 2006; Moore and Measham, 2011), or the persistence of pleasure in the binge drink culture (Measham, 2004). Over the years other scholars have noted the absence of pleasure in drug policy research (O'Malley and Valverde, 2004; Duff, 2008; Bunton & Coveney, 2011; Schnuer, 2013; Ivsins and Yake, 2020). More recently Lancaster et al (2017) discuss the role of pleasure in the medicinal cannabis discourse, and note that "*Silence around pleasure in drug policy is not a neutral absence but rather political in its effects, profoundly shaping how drugs (and the people who use them) might be thought about"* (118). This political silencing of pleasure is encouraged by the liberal ideology that sees drug use as a threat to the autonomy of the rational choice human (Moore, 2008, 356; Keane, 2002, 3-4; Manderson, 2005, 49). Drugs are seen as being a '*powerful and destructive force'* (Keane,

199. 64) that give '*promises of pleasure so potent, so alluring, that it tricks the subject in the first place, then traps them and finally entombs them* (Manderson, 2005, 43). It is evident from this brief exploration of the topic therefore, that the role of pleasure in drug policy discussion is largely absent, and to include such concepts may threaten the very foundations upon which our current liberal based social structures rest upon.

Yet, it is not so much that pleasure or the happy drug user is ignored completely within drug policy discussions in Scotland, but the tactic of side-stepping is practiced in order to silence the narrative. The concept of the non-problematic drug user is set out in the 2008 drug strategy where they define three broad categories: experimenters, regular users, and problem users. It is the final category that drug policy appears to focus on. In private discussions of drug use between the drug policy communities, it is commonly accepted that the majority of drug users consume drugs with minimal harm, and they do so for enjoyment. Yet, this acknowledgment is not acted upon once it has been expressed. This sidestepping sits alongside the concept of 'moral sidestepping', developed by Alex Stevens (2019).

In his 2019 article Stevens examines why it is that despite recommendations from the ACMD and other institutional bodies, initiatives that would reduce harm such as drug consumption rooms and heroin assisted treatment, are not being implemented. Stevens analysed parliamentary documents from 2016-2018 and found that there is a practice of moral sidestepping - that is, the acknowledgment of the evidence supporting the initiative (consumption rooms etc) and a side step by stating their own moral belief that taking drugs should be strongly condemned. The result is inaction, and the implication that to act is morally wrong (in a puritanical Christian way) (Stevens, 2019). In Scotland the excuse is that criminal sanctions are reserved, this allows the policy makers to sidestep the tricky questions, without addressing the issue head on – constitutional side-stepping

While policy makers used tactics such as moral sidestepping and silencing to prevent broader discussions of drug use, another important factor for non-engagement of 'happy drug users' in the policy process is the criminal nature of the activity: "*[t]he criminalisation's of most psychoactive drugs smothers the capacity of drug users to play a transparent and influential role"* (Ryan, 2012). Only those who are considered 'problematic users' and therefore excused from their drug taking behaviour as a result of their lack of agency (addiction brought on by poverty/mental health/trauma, and are unable to stop) are considered to be the legitimate focus of participation, and only marginally at this. To suggest that the wider drug using population; the health worker that smokes joints, the nursery teacher that takes a bit of cocaine every now and then, the postman who goes to annual raves or the artist who indulges in LSD, are every bit as legitimate in the policy process as those who have serious problematic drug use, is to suggest that drug use per se is not the problem. This was apparent from the SDPC engagements where many participants who had used drugs, in the past and currently, did not feel able to openly admit it beyond the safety of a group governed by Chatham House Rules. The concept of a 'coming out' day was often mooted,

but once again many felt unable to put their careers and professional persona on the line. Indeed, one professional who is also a regular heroin user commented that if they came out, there was a very strong possibility the police would use their phone to get to their dealer. This is a very real concern, and one that exists in the medicinal cannabis community too. The campaign leader for MCRS openly grows her own cannabis plants for her medicine. The police know because through our engagement with the Police she has spoken about it. However, this has left her vulnerable to criminal prosecutions should the police decide to use this information to make another 'drugs bust'.

If policy is to include the wider drug using community, these findings suggest that use of drugs should be de-criminalised in order to de stigmatise so that voices that cannot and will not be heard feel safe to come forward. Because the dominant narrative surrounding drug use is one of totemic toughness (Stevens, 2009), and people who use drug are 'problems' to be dealt with, those whose livelihoods would be put at risk if they were considered to lack personal control and agency will not raise their heads above the parapet. This labelling of people who use drugs is well documented (Australian injecting and Illicit Drug Users League, 2011; Lloyd, 2010; UKDPC, 2010, Link and Phelan, 2001), and the pervasive nature of the stereotyping is not easy to dismiss. As the Australian Injecting and Illicit Drug users League found: '*[t]here are clear and definable ways in which we become labelled a drug users in the eyes of the general community […][but] there are no actions or activities whereby one can become 'unlabelled'"* (AIVL, 2011, 50). This is the fundamental problem facing pubic participation in drug policy making; only those willing to take the risk, or who have nothing to lose by 'coming out', will be engaged at this stage. These drug consumers are invariably already part of the system because they have had to identify (and therefore be labelled) as a drug user in order to access medical and social support. The focus on harmful drug use masks the widespread use of drugs by a variety of different communities, and prevents honest dialogue about the impact drug use has on society as a whole.

Summary

As a result of policy being focused on drug related harm, participation in policy is restricted to certain channels where the government feel they can be most effective. It is evident that they feel they can be most effective in addressing the harms stemming from addiction/dependency and 'problematic drug use', and participatory processes to engage this affected community are developed along these lines.

Yet, because the dominant narrative surrounding drug use is one of totemic toughness (Stevens, 2009) - and people who use drugs are problems to be dealt with as a result of the harm stemming from their use - those whose livelihoods would be put at risk if they were considered to lack personal control and agency will not raise their heads above the parapet. This is the fundamental problem facing meaningful participation in drug policy making; only those willing to take the risk, or who have nothing to lose by 'coming out', will be engaged at this stage. These drug consumers

are invariably already part of the system because they have had to identify as a drug user in order to access medical and social support. The focus on harmful drug use masks the widespread use of drugs by a variety of different communities, and prevents honest dialogue about the impact drug use has on society as a whole.

Chapter 8

Developing a Critical Drug Theory

Introduction

A central proposition at the start of this research was that the narratives surrounding drug use define the process by which the use of evidence and the participation of stakeholders are incorporated into policy making. More specifically, the narratives of drug harm and the medico/legal structures which surround problematic drug use mean that evidence and participation are focused on a small section of the drug using population, namely problematic drug users. This focus is, in part, a result of systemic narratives that have been used to justify policies and practices which disproportionately affect those whose ethnicity, social class, gender, religious, ideological and political viewpoints do not fit into the dominant narrative (UKDPC, 2010a, Hari, 2015; Bancroft, 2009, ch.2; Manderson, 2005; Moore, 2008) .

Chapters 4 to 7 have provided evidence to support this hypothesis, by showing that (i) representation of drug use in Scotland developed as a result of concern around the harms of certain kinds of drug use, (ii) focus on this harm means that participation within policy is limited to advising on medical/public health initiatives such as treatment options, and (iii) those who do not fit within this paradigm find it difficult to engage at any level of the policy making process. Participation in Scottish drug policy is therefore constrained by the historical legacies and institutional narratives that guide policy development. Having developed the argument, this chapter explores the last 'what's the problem represented to be' (WPR) question:

6) *[H]ow can the representation of the problem be disrupted, questioned, challenged, and replaced?*

It will also address a core research question:

> *What is critical drug theory, and how can it help us understand drug policy formation in Scotland?*

In order to answer this question, I will present the development of a theoretical framework I call 'critical drugs theory' (CDT).

The first section of this chapter will set out what CDT is, how it emerged from the research process, and the four pillars that make up the framework. The second section will discuss the role of drug related harm in sustaining the representation of the problem in order to provide a basis for

challenging the assumption that all drug use is harmful. In compiling this chapter I used interview transcripts, observational data including field notes from SDPC/MCRS and other committees, reflection and documentary analysis.

From Racism to Drugs Consumption

The journey to a critical drug theory (CDT) is inspired by critical race theory (CRT), and is ultimately grounded in the broader critical theory framework. CRT grew out of the critical legal studies movement, defined as "*an attempt to understand the oppressive aspects of society in order to generate societal and individual transformation*" (Tierney, 1993, 4; Crenshaw et al, 1995, Delgado and Stefancic, 2017). The aim of CRT is to challenge the foundations of liberal thought by linking the outputs such as equality theory, legal reasoning, rationalism and the alleged neutrality of law, to broader questions around their historical development and implementation (Delgado and Stefancic, 2017, ch.1). It contends that the concept of race is a social construct, and that racism is embedded within the framework of most institutional settings, and most modern minds. In order to challenge these frameworks it seeks to use minority and marginalised voices through the use of storytelling and narratives to highlight the impact racism has had on these communities, and to break down the defined social order (Crenshaw et al, 1995; Soloranzo and Yosso, 2010).

CRT became distinct from critical legal studies because of a perceived inability to incorporate analytical frameworks which take into account race and other social injustices (Yosso & Solórzano, 2008). It has now evolved beyond the black white binary and incorporates among others feminist critical theory (Rhodes, 1990), Latino critical theory (Soloranzo & Yosso, 2010) and Asian critical theory (Delgado, 1995a; Yosso & Solórzano, 2008). Like many other marginalised communities, drugs consumers suffer from institutionalised stigma, oppression, criminal sanctions and social alienation as a result of their drug use (Scottish Government, 2015, 2018; UKDPC, 2012). While it could be argued that race/ethnicity is not a lifestyle choice and taking drugs is, this lacks depth in understanding why people use drugs. Importantly, while a liberal drug theory would argue that drug users shouldn't be judged because drug taking is not a free choice, critical drug theory rejects the terms in which choice is framed and argues that drug users' experiences are legitimate in themselves, much like critical race theory does by rejecting liberal critiques of racism. While CDT ultimately stems from the increase in critique of the foundations that drug policy rests on, it is the tenets articulated in CRT that led to the development of the CDT framework.

Developing a Critical Drug Theory

Critical race theory is still a developing concept (Delgado 2011) but broadly speaking there are five tenets that provide the framework of analysis (Delgado & Stefancic, 2012; Solorzano & Yosso, 2010; Yosso & Solórzano, 2008).

The following tenets have been taken from the works of Richard Delgado (1995, 2012), a leading figure in the CRT movement, and Soloranzo and Yosso (2001, 2008), also leading figures in more recent developments of CRT. It was knowledge of these tenets that made it possible to see similar themes arising from my own data, and from that an understanding that such a framework could serve to legitimatise critique of the foundations that drug policy rests upon. The development of theory, or theorising, is not a straightforward process, and "*[t]o theorize well, one needs inspiration, and to get inspiration one can proceed in whatever way that leads to something interesting – and that means any way* (Swedberg, 2012, 6). For myself it was a combination of basic knowledge of critical race theory, an in depth understanding of the marginalisation of drug users, and inspiration from one of my reviewers in my first year board review, all of which led to me begining the development of CDT. The following four pillars have adapted the CRT tenets to demonstrate how CDT developed out of them.

The Four Pillars

CRT, as outlined above, is grounded in a critical tradition which challenges the dominant liberal narratives, specifically those which maintain the legal and educational institutions (Delgado, 1995a). It challenges the dominant narrative that accepts race as a natural order by arguing that it is a product of ontological power (Crenshaw et al, 1995). In doing so it seeks to create change through action, storytelling and giving voice to those who have been marginalised and silenced. This silencing of marginalised voices is not constrained to race however.

Drug use has long been seen as a deviant activity (Becker, 1963; Young, 1971), with those using drugs often identifying with a specific cultural scene such as jazz musicians, mods, ravers, phsychonauts and so on. Furthermore, it is now well documented that historically drug policy has been used to target certain communities or groups of people that appear to threaten the dominant social order (Fitzgerald, 2015; Hallam, 2018; Race, 2009). Drug use (and users) can therefore be considered a marginalised community, and the following four pillars have been developed to show how CDT reflects similar concerns as CRT.

<table>
<tr><th colspan="2">The Social Construction of Drug Use
Social construction as a term comes with its own problems (see further Lancaster, 2014; Wagenaar, 2015, ch.7), however, "it is there for a reason…that reason is to rouse, to incite, to raise consciousness. The point of using constructionist talk is to be critical of the status quo." (Wagenaar, 2015, 117).</th></tr>
<tr><th>Critical Race Theory</th><th>Critical Drugs Theory</th></tr>
<tr><td>In the context of CRT it is the historical construction of race, and structural determinism within legal institutions that has most importance. CRT holds that historical racism stems from colonialism and the use of tools such as land grabs that saw large swathes of indigenous peoples land being taken over. Colonists needed to justify this action by viewing the indigenous, or people of colour, as inferior and therefore not capable of utilising the land effectively. Furthermore, law is written at a certain moment in history and then, by its very nature of being part of the structure and language of that time, can only be changed slowly, unless there is a radical shift in understanding. This results in systemic racism which is very difficult to challenge (Delgado & Stafancic, 2001; c.f. Kimberley Crenshaw).</td><td>Similarly CDT contends that drug use, drug users and drug harm is socially constructed: historically and legally. It is well documented that the evolution of drug regulation is based on temperance ideology, fear of social groups that challenge the status quo, and a desire to control certain behaviours in society (c.f. Duster, 1979; Schnieder & Ingram, 1993, 2005; South, 2002; Bancroft, 2009, ch.2-3; Hari, 2015; Bourgius, 1998; Sarang et al, 2010; Manderson, 1995). Similarly, the construction of harm and use is based on a certain moral ideology: for example the UK Misuse of Drugs Act 1971 (MDA 71) sets out the parameters of whether a drug should be added by looking at its propensity to be misused to the extent that they cause a social problem (MDA 71, S.1(2)., emphasis added). This highlights the nuance, and ability to construct the narrative around these terms depending on the moral and ethical viewpoints of the constructors.
What is meant by misuse and social problem are contested, and measurements of harm are arguably based on pre-determined ideas of what was consider unacceptable behaviour (see further Nutt et al, 2007). More recently the UK Government have been explicit in their moral ideological stance that overrides evidence informed policy making (Stevens, 2019). This explicit statement of intent highlights the historical power dynamics that still exists within all aspects of policy, and is especially prevalent in drug policy.</td></tr>
</table>

Institutional Power Challenging the dominant ideology and a commitment to social justice	
Critical Race Theory	**Critical Drugs Theory**
The challenge to a dominant ideology – CRT challenges and refutes the claim that educational institutions in particular make towards 'objective, equal opportunity, colour blind race neutrality' etc. In fact these claims serve as masks to hide behind which, if uncovered, reveal the self-interest and power politics of the dominant groups in society, namely white, privileged (wealthy) men and women. It seeks to undermine and challenge the assumptions held by these institutions.	Similarly, CDT seeks to challenge the dominant ideology: that all drug use is bad, and the goal of drug policy is to eradicate all drug use and/or abuse (UN Political Declaration, 1998; The Scottish Government, 2000). This ideology ignores the role drug use plays in many cultures such as indigenous cultures and other uses that are practiced by people today (see further M.A.P.S.; Beckley Foundation). Further, it silences discourse on the pleasure of taking drugs, the role they can play in social cohesion, understanding consciousness, recreational activity and stimulation (Carhart-Harris & Nutt, 2013). By focussing on the harm of drugs, it ignores the harm of the legislative framework that limits the availability of drugs, by criminalising all psychoactive substances (Babor et al 2018, ch.5).
CRT is committed to social justice using transformational dialogue, and works to transform the power structures which maintain dominant and oppressive narratives. It recognises that social institutions often work in contradictory ways – on the one hand maintaining the oppression and marginalisation, but on the other hand have the potential to empower and transform. CRT has involved projects which help to raise the level of the literary consciousness by 'naming the problem/injury'.	CDT is also committed to social justice and transformational dialogue. It aims to highlight the role social institutions play in reinforcing the dominant narrative of drug use and drug users, and the continued oppression of those who choose to alter their consciousness. Furthermore, it seeks to challenge the legislative frameworks that create and perpetuate much of the social harm associated with drug use, and frames drug use in terms of problematic, harmful and criminal. An example of this can be seen with the Scottish Recovery Consortium (SRC) which, as a government funded institution is part of this 'institutional power'. However, they are using this 'power' to challenge deep rooted stigma towards drug users: *The dialogue of stigma is coming from the professionals, but also these professionals are the ones being charged– through anecdotal evidence collected by the SRC and other advocacy*

	stories – of enacting stigma (Mental health services, NHS, G.P's, Treatment Services) (field notes from LLEEG, 2017

Intersectionality **The intersection between multiple communities and multiple disciplinary approaches**	
Critical Race Theory	**Critical Drugs Theory**
CRT recognises that racism intersects with other marginalised groups in society such as women, LGBTQI, disadvantaged and people with disabilities. Race therefore is one defining characteristic that contributes to greater injustices and oppression when combined with other marginal characteristics. Intersectionality is a theoretical development that grew out of CRT and is now well established (Carbado & Roithmayr, 2014). The theory was first elaborated by Kimberley Crenshaw (1989, 1991) where she "*exposed and sought to dismantle the instantiations of marginalization that operated within institutionalised discourses that legitimized existing power relations (e.g., law); and at the same time, she placed into sharp relief how discourses of resistance (e.g., feminism and antiracism) could themselves function as sites that produce legitimized marginalization"* (Carbado & Roithmayr, 2014, 304)	Similarly drug use intersects with all sections of society, there is no typical drug user, although there are *perceptions* of what kinds of drug users there are. However, when drug use is combined with vulnerable or marginalised characteristics such as gender, race, sexuality, physical disabilities, trauma and mental health issues, there is an increased risk of physical, psychological, social and institutional harm. Importantly the impact of laws surrounding drugs has resulted in discrimination against ethnic minorities in the UK (Shiner et al, 2013, Release, 2013; Roy, 2011), or the policing of crack users in the US, highlighting the intersection between race and drug policy. However, this intersectionality also exists within drug using communities, as Crenshaw highlights for CRT. Within these communities there are different kinds of users, and those who intersect with other marginalized positions such as gender, race and poverty, are disproportionately impacted by drug policy interventions as result of the structure that maintains it - enforcement and treatment. In addition stigma towards different kinds of drug use, as seen in the discussion of harm below, can result in legitimized marginalisation of different kinds of drug users, by the drug using or drug policy community.
CRT draws on multiple disciplines to highlight the impact historical and current racism has. By using a variety of disciplines, CRT seeks to challenge current models of scholarly investigation	Similarly, CDT seeks to utilise multiple disciplines that play a large role in suppressing, but also transforming the oppression and stigma directed towards (and within) drug users and their communities. Pertinent to this tenet is the way in

	which evidence is presented in drugs policy (Lancaster, 2014; MacGregor, Singleton, & Trautmann, 2014; Smith & Joyce, 2012)

Narrative and Counter Narrative **The centrality of experiential knowledge**	
Critical Race Theory	**Critical Drugs Theory**
CRT recognises that the stories and voices of those who have experience are important to understanding and analysing racial subordination. CRT sees experiential knowledge as a strength which can be used to inform research and policy decisions by widening the concept of evidence to include knowledge based on storytelling, biographies and narratives.	Similarly CDT recognises that experiential knowledge of drugs and their effects should play a role in policy relevant issues such as how harmful a drug is, what the social impact of different kinds of drug use have, and wider concepts regarding principles underlying drug use and regulation. The reasons for using drugs are as varied as they are diverse, and until the experiences of drug users are legitimised their voices will be marginalised and silenced.

What is Critical Drug Theory?

The development of CDT stems from the increase in critique surrounding how drug policy is made and implemented from scholars such as Schneider and Ingram (1993) Carol Bacchi (2009), Alex Stevens (2010), Alison Ritter (2011) and Kari Lancaster (2014), to name a few. These critiques have highlighted the issues surrounding how evidence is produced (Lancaster, 2014; Stevens & Ritter, 2013), how drugs problems are constructed (Bacchi, 2012, 2016; Schneider and Ingram, 1993) and how drug related harm is measured (Rolles & Measham, 2011; Stevens, 2008). A common thread running through the most critiques of drug policy is the recognition that policy fails to address fundamental questions relating to how and why drug policy is implemented, such as: what is evidence *informed* policy (see further Lancaster and Ritter, 2018; Smith, 2015); what is drug related harm, what level is acceptable; and what is problematic drug use? In order to explore these questions researchers are required to challenge the very foundations that drug policy rests on: that drug use causes unacceptable levels of harm to individuals and society. Indeed, CDT would question the very basis of harm as a metric for evaluation, in light of the discussion below on the experiential perception of harm. The focus on evidence based, or evidence informed policy for example highlights the difficulty in getting under-represented voices into policy discussion because of the institutional reliance on certain kinds of evidence.

Critical drug theory is therefore a theoretical framework that uses the paradigm of the four pillars outlined above to challenge the assumption that drug use always causes harm, and ergo policy is focused on reducing the harms from ‘problematic’ drug use. It asserts that drug use is a

social phenomenon, and the focus on harmful drug use is a result of institutional narratives that determine what acceptable social behaviour is. Reiterating the above, CDT contends that the narratives of drug harm and the medico/legal structures which surround problematic drug use means that evidence and participation are focused on a small section of the drug using population, namely 'problematic' (harmful) drug users. This focus is a result of systemic narratives that have been used to justify policies and practices which disproportionately affect those whose ethnicity, social class, gender, religious, ideological and political viewpoints do not fit into the dominant narrative. By using aspects of the four pillars to develop research projects or critical analysis, these systemic narratives can be countered and challenged.

The four pillars of CDT intersect with one another, but for the purpose of this thesis I am focusing on the role that narrative, and more specifically counter and Meta narrative, can play in challenging systemic (master) narratives. In order to do this, I will take the master narratives that have been identified in the previous chapters and explore how counter narratives, and meta-narratives (Roe, 1994; Fischer, 2003) can help to disrupt, question, challenge and replace them (WPR #6).

The focus on harm is also evident throughout this research, with the harm of drug use - and the problems that result - being the main focus of all policy interventions. In order to address this underlying assumption we must explore what is meant by drug related harm, and how this influences drug policy.

The Role of Harm in Drug Policy

As we have seen, drug policy, in Scotland and beyond, claims to be focused on reducing the harm thought to be caused by problematic drug use (Caulkins et al, 2011; Rolles & Measham, 2011; Scottish Government, 2008, 2015, 2018). While the thesis has explored what problematic drug use is, and challenged this, it has not yet addressed what is meant by harm. This section explores what is meant by drug related harm, and whether there are valid critiques on the current concept.

In discussions of drug related harm there is a tacit agreement between key players within the drug policy community what it constitutes – namely harm stemming from 'problematic drug use'. Indicators such as deaths recorded as drug related, hospital admissions, crimes, access to treatment services and social service contact are all used in calculations of drug related harm (Stevens 2007, 2008; Babor et al, 2018, ch.2-3). For example, crime that is recorded as linked to drug use is recorded as a drug related harm and used by the UK Government in their Drug Harm Index (DHI) (Stevens 2008). All recent research used by the UK Government (Godfrey et al., 2002; Gordon et al., 2006) and the Home Office's DHI (MacDonald, Collingwood, & Gordon, 2006; MacDonald et al., 2005) assumes that the drug *use* causes the crime and therefore can be

taken into account when weighting the DHI. There had been an established body of literature that purported to show associations between drug use and criminal activity (Gossop et al, 2005; Hall et al, 1993, Keen, 2005; MacIntosh, 2007). However, in 2017 a systemic review of the link between criminal activity and opiate users found that:

> *"Available evidence suggests that onset-opiate use accelerates already-existing offending, particularly for theft. However, evidence is out of date, with studies characterised by heterogeneity and failure to use a matched non-opiate-user comparison group to better-establish whether onset-opiate use is associated with additional crime"* (Hayhurst et al, 2017, 1).

Others have argued that there are assumptions built into how crime is recorded, among other things that often mask underlying subjective decisions on whether the crime was drug related or not (Stevens, 2007, 2008). Alex Steven (2008), among others, has highlighted this issue by showing that while there may be a correlation between drug use and crime, there has been an exaggeration of the link (Stevens, 2008). It is argued that police discretion can result in discrimination towards certain groups in society such as drug users: crucially drug users from lower socio-economic background, or those from ethnic minorities (Fielding 2005; Reiner 2000; Stevens 2008, Release, 2013). As a result of the over representation of these kinds of drug users in the criminal justice system, the link between drugs and crime is exaggerated (Stevens, 2008, Release, 2013).

Measures of drug related harm encompass drug related crime but also 'social harm 'thought to be caused by drug use. In Scotland 98% of drug related crime is specifically related to offences under the Misuse of Drugs Act 1971 (Scottish Government, 2014), and this narrows the scope for subjective interpretation of what constitutes drug related crime, although as seen above there is debate on how this data is recorded and reported. Drug related social harm however is prone to subjective evaluations of what constitutes a social harm. In Scotland social harm relating to drug use encompasses drug related crime, child protection data, and public surveys on the *perception* of drugs (Scottish Government 2014). The latter measurement is extremely problematic; that public *perception* of harm is taken as a measurement of the *actual* harm caused by a drug. In particular, the perception that violent crime is causally related to drug use (Scottish Government, 2014), as opposed to other important factors such as gang culture, poverty and male violence, highlights the disproportionate focus drug use has in regards to social harm. Furthermore, there is an argument that much of the crime is a result of the illegal nature of the drugs, creating a market governed through violence and intimidation that would not exist within a regulated market (Babor et a, 2018, ch.2&5; MacCoun & Reuter, 2010, ch.6). Drug 'related' crime is therefore often associated and linked to wider organised criminal activities.

These short examples illustrate that even in areas where there appears to be factual evidence, there are multiple layers of meaning written into the concept of drug related harm. While the harm stemming from problematic drug use is of real concern, there is increasing evidence to show that harms stemming from drugs has more to do with systemic societal issues such as life trauma (Mate 2008;), poverty (Carliner, 2015), underlying mental health issues and prohibition (Hari 2015), and the criminal framework surrounding drugs (Babor et al, 2018, ch.5) than drug use per se.

It is apparent therefore that interpretations of what constitutes drug related harm are predominantly governed by concepts of harm which in many instances are a result of shared narratives which have entered the lexicon of drug policy. Furthermore, these interpretations are guided by moral concepts of how people should act (Stevens, 2019), and the levels of harm acceptable within society. The experience of the wider drug using populations are set aside in order to focus on a small group within this population. In order to widen the lens of understanding on what constitutes drug related harm and pleasure, the experience of *all* drug users should explored.

Yet in order to do this, the experience of all drug users must be considered valid. However, as discussed in the previous chapter, participation in the policy process is governed by the narrative of drug harm, and therefore discussion of pleasure or enjoyment in drug use are seen as attempts to undermine the goal of drug policy: to prevent the harm resulting from problematic drug use.

Counter Narratives to Harm

One of the major stumbling blocks within the drug policy making process, and indeed all processes involving scientific measurements of harm and pleasure, is the role of personal experience. Traditional scientific research methods such as randomised controlled trials with double blind controls, have had difficulty with the concept of personal experience as a form of evidence and therefore tended to ignore instead of explore. However, within drug policy research it is increasingly understood that examining the experience of a range of consumers and the impact this has on individual understanding of harm and pleasure, allows us to explore differences in perception between drug consumers, experts and policy makers, and therefore arguably create better policy solutions for society as a whole.

There have been a number of studies which have looked at how people who use drugs think about harm and drug policy (Darke & Torok 2013; Lancaster et al. 2013; Lancaster et al. 2014; Morgan et al. 2010; Carhart-Harris & Nutt 2013; Lancaster et al. 2015). Much of the literature concerning the experience of drug consumers has focused on qualitative research with injecting drug users (Lancaster et al, 2013, Lancaster et al, 2015) or secondary data research involving large scale surveys/questionnaires ((Carhart-Harris & Nutt 2013; Morgan et al. 2010; Lancaster et al. 2014). Gaps in the research remain however and these include research with non-problematic drug

users (McPhee, 2012; Morgan et al 2010), the impact of pleasure on measurements of harm (Carhart-Harris & Nutt 2013; Morgan et al. 2010), and the impact of prohibition on levels of drug related harm (Rolles & Measham, 2011).

In 2010 Dr Celia Morgan and others set up a study in response to growing interest in the concept of a Multi Criteria Decision Analysis (MCDA) developed by David Nutt and others (Nutt et al. 2007) and designed to improve the ranking of drug harms. This research created a national drug survey to measure not only the perceived harmfulness of certain illicit drugs, but also their perceived benefit. Findings from the survey were consistent with previous findings with experts regarding the high ranking of harmfulness for drugs such as heroin and cocaine, and the low ranking of harm for drugs such as MDMA and cannabis (Morgan et al, 2010).

Similar research conducted with regular illicit poly drug users found that heroin was ranked by drug users as one of the most harmful drugs alongside cocaine, and MDMA was rated one of the least harmful, supporting Morgan et al's findings (Carhart-Harris & Nutt, 2013). In the latter research, pleasure was also ranked and heroin was found to have a pleasure rating in the middle, and MDMA was found to have the most acute pleasure rating (Carhart-Harris & Nutt, 2013). In this research respondents were given space to elaborate on why they considered a drug to be harmful or beneficial. This allowed qualitative feedback on decisions and importantly findings showed that reasons for pleasure/benefit rankings were often based on their therapeutic qualities (Carhart-Harris & Nutt, 2013). This most recent research illustrates the importance that more in depth analysis into the impact pleasure and benefit has on individual measurements of harm, and this is where CDT can elaborate. CDT in particular the use of personal stories and larger combined narratives can highlight the context specific perception of pleasure. Much of the research around pleasure and harm does not elaborate on what pleasure actually is, or how it is perceived. Because of the reliance on traditional scientific methods, even within the qualitative field, pleasure becomes a box to measure something with, rather than an experience to understand (Race, 2017). In the following chapter I look at narratives around drug use, and I begin to develop a more nuanced understanding of the uses of drugs, and the ways in which individuals experience pleasure as a result of their social context. This helps those who may not have had that experience, to understand why someone would continue to use an illegal substance despite the harm, both physical and criminal, that may result.

One of my interviewees, who highlighted the harms resulting from drug use, relates an interesting aspect of drug related harm. In this story, the harm from drug use is a physical harm, akin to the kind of harm you would get from excessive exercise. Indeed, the storyteller equates these harms in order to highlight how our risk/reward decisions are different depending on what we view as pleasurable, or important. Another interesting aspect to note in this story is that a different harm – anxiety – is brushed over as a normal side effect.

Senior Policy Officer: "So ,it's a bit like having a hobby and you'd say oh I've got blisters because I bought new running shoes or whatever, you know, I've got a sore knee because I jog or whatever, two experiences I've never had…[laughter]…but you know, people in the office say these things, you know these are harms that are to do with a lifestyle choice, but they are just part of it. And I had, talking of blisters, I…at one time that summer I was using amphetamines heavily, I had huge blisters in my heels, which I had to burst wi eh needle…

Interviewer: From dancing?

Senior Policy Officer: no, no from walking, I used to walk at night, and I used to walk in a particular gait because I was so out my face [laughter]. So I couldn't sleep, and I used to walk along Great Western Road in Glasgow, which is a great big long straight road. I mean I used to walk miles and miles and miles up the road, and then back down again, and past the flat and go past the flat and go, I can't go in, an then go back to George's Cross and then back out to Anniesland, and it was some big big distances. And I developed these huge blisters. And I had a bit of mental health stuff, bit of kind of paranoia, but of kind of edginess and stuff like that, which was the stuff I didn't like about cannabis but I put up with with amphetamines. And I had a lot of sleep disturbance, and when I wasn't using I'd problems with my sleep patterns and all the rest of it…eh…and when I look back on it as a middle aged person now I used to… I mean I used to think you weren't really there unless you could feel your heart pounding in your back. So I mean it wasn't just that your heart was racing in your chest, but you could actually feel it in your back, so if you leant your back up against a wall you can feel it. That was my 'right aye, that's me up' [much laughter] I can go to that party or whatever."

What is being highlighted in this story is that we accept certain harms if they are associated with activities considered to be healthy. So a sprained ankle from jogging, or sore limbs from exercise are seen as a legitimate harm, whereas harm accrued from drug use is not. Furthermore, the story highlights that when using certain drugs we put up with some harms, because the effects (whether pleasurable or not) are worth the resulting harm.

The use of drug for pleasure is often overlooked by a policy focussed on harm, and indeed, if policy were to accept that people have a right to use drugs (the human right and cognitive liberty argument) then justifications around pleasure become null and void. However, policy is still focussed on the overriding harm of drug use, and extracts from one of my interviewees highlights this issue about pleasure and policy:

"recreational drugs, MDMA - ecstasy is the worst drug out there for trying to say there is anything bad about it because I look at the people, I have been to T in the Park I've stood behind Pete Tong, watched 6000 people all under the influence… And they were all under the influence of ecstasy having a great time. There's no fighting, they're dancing,

having a really good time, you don't get pitched battles in the slam tent...that's the user experience, [it] is a really hard drug to stand up and say 'gonnea no dea tha' [go and not do that] because it enhances the whole experience. And I think ecstasy is an example of a drug that actually highlights better than any of the drug why it's taken and the benefits of taking" (Retired Police Officer).

This participant was attached to the drugs division of Strathclyde Police at the time he is talking about, and witnessed the use of ecstasy at large festivals. Here he is talking about the pleasure that festival goers experience from taking ecstasy, and the non-violence associated with it. '*You don't get pitched battles in the slam tent'* is saying that there are no fights associated with taking the drug. And he hits on a real issue facing drug policy – how can a policy focussed on harm take into account the lack of harm experienced by millions of ecstasy users on a weekly basis[33]. Furthermore, as CDT would highlight, there's a key distinction between on the one hand saying the policy and science fails to take account of harm and pleasure in properly calibrated ways; and a more fundamental critique that it is incapable of doing so because it cannot capture the reality of why people use drugs in the first place. The following extract is an endorsement of LSD by one of my interviewees:

Senior Policy Officer: Interviewee: "Especially LSD absolutely. I mean I can't understand what it must be like to have never used acid in the sense that it's so…what it gave me was the insight that a different perception that seemed absolutely valid… is possible. So a colour can be another colour. And of course that's what it is to be somebody else, to see something in a completely different way. So I just think it makes you so much more - I don't mean in the MDMA sense of empathic - but I think you understand difference a lot better when you realise that simply putting chemicals in your brain can make you see the world in a different way, for your thought patterns to be different and all the rest of it. It's a huge insight.

Interviewer: So just to finalise, when you think of that drug period in your life, it's not a negative time in your life?

Senior Policy Officer: no, no. The best things I had in my life, in terms of just pure fun, were all drug related."

Interviewer: Right.

Senior Policy Officer: I would recommend drugs to anyone who could use them in that way."

[33] The crime survey for England and Wales (Home Office, 2016) recorded 492,000 people taking ecstasy. Similar statistics do not exist for Scotland, although the 2017/18 Scottish Crime and Justice Survey reported that 7.4% had taken drugs in the last year. Given that both surveys reach is limited, it is not unfeasible (in my opinion) to assume that a million or more people are using it on any given Saturday night all over the UK, particularly during the summer season.

The important insight to be drawn here is that experience and personal knowledge of a drug and drug using cultures appears to influence the perceived harm and pleasure of that drug. For example, Darke and Torok's research showed that regular injecting heroin users rank heroin in the same harm category as MDMA (2013), yet regular psychostimulant users rank heroin as significantly more harmful, and MDMA as one of the least harmful and most pleasurable drugs (Carhart-Harris & Nutt, 2013). If it is assumed that these regular psychostimulant users have little experience of heroin use, then Darke and Torock's research provides support for the argument that user experience of a drug can determine how harmful that drug is perceived as being. There are complex issues therefore to do with the impact personal experience has on how we measure drug related harm, and ergo how we legislate to mitigate the impacts of drug related harm. Arguably most legislators are not regular consumers of illicit drugs, or consumers of only one type of drug, and therefore their perception of drug harm is guided by master narratives on how harmful drug use is.

This exploration of harm is important because it helps to frame the overarching narrative within drug policy - that of *harm* resulting from drug use and how to respond to such harm. Yet, as this section, and previous chapters has shown, this harm is often context-specific and involves a complex interplay of social, political and historical aspects.

Counter-narrative and Meta-narratives in CRT and CDT

CRT has a long history of using storytelling and narrative to explore how people view race, and how people of colour experience racism. It is used to provide a counter narrative to the dominant white narrative (Bell, 1987; Delgado, 1995a, 1995b). One reason storytelling is important in CRT, and CDT, is that is opens a window onto alternative realities that are not available to white people (CRT), or in the case of CDT, those who have no experience of drug use, or different kinds of drug use.

Counter-story telling helps to shine a light on historical and current narratives that hide the often-brutal role law and institutions play in the suppression of people of colour (CRT), or drug users (CDT). Johan Hari's book 'Chasing the Scream' (2015) delved into the personal stories of those impacted by the drug laws, giving us stories which emphasize the role that poverty, institutional oppression, racism and brutality plays in maintaining the dominant narrative. Through personal stories and collective narratives, the hidden can be revealed, and the de-humanisation of those considered 'other' can be challenged (Smith, 2012; Tyler, 2013). Counter-storytelling in CDT not only focuses on the stories of people who use drugs however. Narratives of change and the suppression of certain voices exist within all levels of the policy making arena (as does drug use), and counter – storytelling can give voice to these stories. Counter storytelling therefore, serves to challenge deeply embedded cultural and structural beliefs. It also provides avenues for

those whose voices are silenced or suppressed, to challenge the dominant narrative and highlight evidence which undermines it.

Throughout the thesis I have provided the master narratives in the form of the institutional response to the perceived drug problem in Scotland using the WPR Approach. This approach has also provided counter narratives - such as the silences and ignored narratives - and critiques to illustrate aspects of the findings. In the following chapter I shall tell stories based on the master narratives that emerged from the previous chapters, and provide counter narratives from my data. In doing so we will begin to see the emergence of meta-narratives: narratives that "*offer the analyst a way of entering and reframing controversies that can lead to new ways of seeing capable of moving the disputants beyond policy implications*" (Fischer, 2003, pp.179). My construction of meta-narratives follows Roe (1994) by using master and counter narratives to construct a meta-narrative. However, if I am honest, I found Roe's approach simplistic and too structural. I also felt that while it sought to add value, the policy analyst is still coming to their own conclusion. As Fischer points out, these conclusions need the analyst to make quite large normative assumptions, yet Roe does not incorporate those normative assumptions into the analysis (2003, ch.8). I too struggled to overcome the normative assumptions, and as discussed in chapter 2, in some ways I have not overcome them, nor is it ideal that I do. However, I believe I overcome this analytical problem by developing many different narratives using the process set out by Fischer (1989; 2003;2009) in his 'analytics of good reason':

> *"It is through storytelling that people assess social positions in their communities, understand the goals and values of different social groups, and internalise social conventions. Narrative stories do this by imposing a coherent interpretation on the whirl of events and actions that surround us. Threading these sequential components together through storylines, narratives place social phenomena in the larger patterns that attribute social and political meaning to them. In the process, the storyline is at the same time an invitation to moral reasoning"* (Fischer, 2003, pp.179).

The meta-narrative is a form of moral reasoning. By developing different narratives, and using elements of both the master and counter narrative to construct a meta-narrative, the goal is to provide an alternative story that speaks to both the inherent risk in the stories, and underlying moral reasoning. The challenge in constructing meta-narrative for drug policy stories is that there are some people, both in policy and in the wider public, who believe that the goal of policy is to eradicate all drug use. This is technically impossible and, arguably, morally unreasonable, and therefore my meta-narratives will not be able to speak to those who are adamant that this goal should persist. Instead, these meta-narratives seek to show the reader an alternative outcome that speaks to the sensibilities of a range of viewpoints.

Summary

CDT is a work in progress and will need to be developed and tested by myself and other scholars in order for it to become part of the critical theory landscape. However, it is grounded in critical thought with the underlying premise that the foundations of drug policy, national and international, are based on ideological reasoning that is often used to suppress and silence those who seek to challenge the status quo. Subjecting policies to critical evaluation, such as research into the impact drug laws have on individuals and society (as opposed to the impact drug *use* has), should be advocated, along with public engagement on the complexity of drug use, pleasure and harm.

The following chapter explores the narrative pillar of CDT. By combing all the individual stories, and broader narratives present in my data, I have developed a series of narratives that set out the master, counter and Meta narratives of this thesis.

Chapter 9

Exploring the Narratives

This chapter will use fictional narratives, developed from the data and my background knowledge to explore two core research questions:

- *'What are the master and counter narratives within Scottish drug policy communities?'*
- *'What are the challenges in engaging different epistemic communities in a participatory policy process?'*

In doing so it will address the final core research question by showing that narratives of engagement and participation, as well as historical narratives, can provide a counter and meta narrative – critique- that has the stability, or certainty needed to provide an alternative course of action. The final research question is:

- *What is critical drug theory, and how can it help us understand drug policy formation in Scotland?*

Finally, this section will address #6 of the WPR approach:

- *How can the representation of the problem be disrupted, questioned, challenged and/or replaced?*

The representation of the problem is the overarching master narrative that encompasses all aspects of drug policy, and provides the frame(s) for which drug policy is negotiated and enacted. The counter narratives are the competing narratives – stories and narratives that are evident in drug policy communities, but remain hidden, silenced or ignored. The Meta narrative is a combination of both the master and counter narrative that shows how policy could be enacted to take into account the different viewpoints and situations of the policy stakeholders. The following sections in this chapter each present three narratives - the master, the counter and the Meta narrative – addressing the two key areas that the thesis has explored: historical legacies of drug policy, and stakeholder participation in drug policy. It will also link to the development of CDT, by starting to provide justification for the development of the theory. As Swedberg (2012) notes '*creativity is primarily what matters when a theory is devised; and scientific logic and rigor is primarily what matters in the context of justification'.* It is hoped that by presenting these fictional narratives as amalgams of the stories present in drug policy, the reader will see the creativity that helped develop this theory, and the logic of using narratives to highlight the impact current and potential policy decisions have on marginalised or silenced groups, and ergo the logic underpinning CDT.

As discussed in chapter 2, if there are different narratives around complex policy 'problems', policy makers will fall on ambiguity and harden the master narrative line, because this provides security and strength to an issue which is complex and full of risk (Roe, 1993; Stone, 2002). It has been argued therefore that policy analysts should focus on the structure of the narratives, both master and counter, and explore the similarities and differences in order to craft an alternative story that deals with the uncertainty and risk inherent in all complex policymaking (Roe, 1994, ch.2). Using personal stories to highlight policy narratives (both master and counter) allows the researcher to craft *Meta* narratives that speak to both the policy making community, and the wider stakeholder community. In doing so the counter and meta narratives can attempt to provide the security, coherence and structure needed to create understanding of these complex 'problems' and provide viable alternatives by providing insight into the different competing narratives.

The narratives presented here are an amalgamation of multiple stories and narratives that present the representation of the problem, responses to that problem, and counter stories. These stories and narratives come from my engagement with the different policy groups, interview data, field notes, documentary analysis, informal conversations and my background (or situated) knowledge of the field. Further, the characters in the stories are fictional characters developed from my data in order to provide the frame for the kinds of drug use considered legitimate (or illegitimate) in policy participation: the sick, the recovered, the professional and the happy drug user. None of the actions carried out by the characters are representative of any one person, but are reflective of the different situations the various stakeholders find themselves in depending on their context. I will present the master narrative, and then provide counter and meta-narratives for both historical legacies and participation.

Historical Legacies

As seen in part two, the representation of the problem is a result of historical legacies that resulted in a focus on drug related harm, specifically HIV/AIDs and other potentially deadly outcomes from drug use. From this a master narrative was developed encompassing the kind of drug user, and drug use, policy was focussed on. The following stories explore this focus.

Historical Legacies Master Narrative: the representation of the problem

> *"Barry turned the corner and pulled up his collar against the biting November wind. He walked slowly, not really knowing where he was going, just walking, hoping that it may provide some answers. Yesterday was his last shift at the yard, and now him, and most of his pals were unemployed. It was 1986, his dad had lost his job a year ago, and was now drinking himself into an early grave while his mum watched on helplessly. Barry was finding it very difficult to get his head around what his life opportunities were now that he*

was unemployed, in fact he did not have the capacity to think about it at all. His life had not been easy: being a small boy he was a target for the bullies, and his older brother had vented a lot of anger on him. Growing up in a poor industrial estate had taken its toll on him, and he was not a happy young man. As he was walking his pal Neil came up to him, asked him if he wanted to stop by his and try this new stuff a pal had sold him – like hash but better. 'Aye, may as well come up now, just walking around here wearing ma shoes out'. The first smoke of the brown sticky stuff that smelt like burnt vanilla made him violently sick, and then horrendously itchy. His pal Neil told him to give it another go 'it takes time to get used to it but when you do…

The second time Barry got it. He well and truly got it. You know when you have found your drug of choice, and Barry had found his. When he sank back after his hit he could feel the years of tension slip from his shoulders, his body slowly forgetting the memory of bruises, pain, shame. Wrapped in a warm fuzzy loving embrace, Barry felt safe for the first time in his life. Unfortunately this feeling cost money, and Barry had no work, and no prospect of work in the near future. The more he took, the more he wanted, and gradually he forgot about 'career choices' and spent his days finding ways to get his fix for the night. Fast forward 30 years and Barry has been dependent on heroin for three decades, most of which has been spent in and out of jail for small crimes, staying in various homeless shelters, temporary accommodation. The periods of sobriety or permanent housing never lasted long."

Now, this story has two endings, depending on what is being depicted: recovery or drug related deaths.

The recovery ending:

Barry was tired: tired of being homeless, tired of the street life, tired of needing to intoxicate himself to just stay alive. At the urgings of his support worker Barry started to attend his local NA sessions. In this he heard about the concept of recovery, and began to think about his life, all the trauma he had experienced both in his childhood, and as a result of his addiction. His G.P. was encouraging him to reduce his methadone script and she had offered to put him in contact with his local recovery community. One day Barry made contact with the community, and since then it has been a journey of discovering a new support system that has helped him become drug free, and able to hold down a tenancy. Barry is very happy in fact he is 'better than well' 34

[34] A phrase recently coined by the recovery movement to describe how those who have been drug free for a certain period of time begin to feel better than people who have never had a drug problem. See further: https://www.scottishrecoveryconsortium.org/index.php?id=1235,

The drug death ending:

One cold November morning Lucy was walking to work past Waverley train station in Edinburgh and she noticed a homeless man asleep on the side of the bridge. She felt sad: nobody should be out begging in this weather, put a coin in his hat and went to work. On her way back from work she noticed that the homeless man had not moved. She made a note in her head to check the next day. The next morning she passed him again, and he was in the same position as yesterday. She decided to call the police to ask them to check up on the man. One hour later she received a phone call from the police to update her: The man had been a homeless man named Barry McGowan, age 53, and he had died from what looked like a heroin overdose. He was given a paupers burial and his funeral was attended by his support worker, and no one else.

Problem drug use began to be a policy 'problem' around the mid 1980's as a result of an increase in HIV/AIDS that brought heroin use to the attention of policy makers, particularly in Scotland. The narrative that is being presented in 2019 is that, as a result of neo-liberal policies by the UK Government which saw the closure of many factories and industries, Scotland suffered a long- term decline resulting in high unemployment, poverty, and an aging drug using population (MacGregor, 2017; Galea et al, 2005; McCartney et al, 2012; Scott-Samuel et al, 2014; Collins et al, 2011; Walsh et al, 2010; Dorn and South, 1987; Minton et al, 2017; Scottish Affairs Committee, 2019; Parkinson et al 2017). This has led to a community of drug users that are either sick or in recovery, and the focus has been on how to encourage these drug users to access recovery based treatment. This story has helped to focus responses to perceived drug 'problems' by providing a stable grounding on where the 'problem' has come from, and a how to respond to it: by increasing access to treatment and addressing the social aspects such as housing, employment, therapy etc.. While these are laudable responses, and will have a positive impact on many 'problematic drug users' who are seeking such treatment, as discussed this focus hides a much deeper complex relationship with drugs in society.

Historical Legacies Counter Narrative: the hidden harm of criminal justice policy

As has been demonstrated, the problem was represented historically as a response to an increase in drug use, particularly opiate based drug use. However, there are counter narratives to this representation, namely the role the criminal justice had (and has) in creating and/or sustaining 'problematic' drug use.

This story is based on stories I came across throughout my data collection, including interviews, but also through my peer group, my work as an expert witness working people who were being prosecuted for drug offences, and individuals and families who attended the LLEEG group I was part of. It links into the silences developed during the 1990's, in chapter five, where

it was argued that the focus on harm resulted in an increased criminalisation of drug users outside the treatment framework. In the prologue I told the story of my friend from my late teens who ended up in jail for drug dealing, and this story incorporates his and many others to highlight the impact the criminal justice system has on drug users.

"Jamie was getting ready for the weekend. Shaz had phoned and her crew were wanting about 20 pills and some hash, Gerry was wanting another 20 pills, and his own crew probably wanted the same. All in all he reckoned if he got 100 pills that would sort everyone out for the weekend and leave some spare in case anyone else wanted any. He called his guy Mark – a dude he'd become friends with from buying pills, and was now effectively working for. 'Mark, I'm gonnea need 100 pills and probably an ounce of your solid if you got it'. 'No worries pal, Come down in an hour and I'll have it sorted'. Jamie started to get ready. He stuck on his thumping house music, poured a vodka and coke, and started to wind up for the weekend. It was gonnea be a belter! Shaz was having her 21st and had hired a massive venue just in Ayreshire, DJ's an all, and the promise of plenty dancing, chatting hugging and all round madness was on the cards. He called a taxi to take him to Mark's.

The taxi pulled up at the high rise in Easterhouse, god he hated this place. Bleak, empty, and nerve wracking. How many busts, stabbings, beatings had taken place down here? He wished Mark was up for meeting at his place in the West End, at least he wouldn't feel he was walking into a warzone just to buy some bloody drugs for the weekend. In and out in 20 minutes, done and dusted. As he was walking down the road trying to hail a taxi (no bloody taxis in this place) a police car pulled over. 'What you doing pal' said the policeman in the driver's seat. 'Just walking, on my way out for the weekend'. The policeman stepped out the car. 'We've been informed that drug dealing has been taking place, and a man fitting your description was seen leaving the suspected premises, we are now cautioning you under section 23 of the Misuse of Drugs Act 1971, for the purpose of a search'.

Jamie was found with 100 ecstasy tablets and 1 ounce of low grade hashish. He was sentenced to 4 years in prison, out in 2.5 years for good behaviour. He was 18 years old, with no dependent drug use or recorded mental health problems, when he entered Barlinnie Prison.

Jamie squinted in the late afternoon sun. His mum and dad had come to pick him up from the prison but he had deliberately told them the wrong time so he could leave without them. He was broken. His body ached from the violations of prison, both from inmates and the different drugs he consumed just to survive the pain. But he also had a craving. He craved the sweet feeling of heroin as it hit his veins, the blind intoxication as the Valium mixed with heroin dissipated all the memories of the last 3 years. He needed more, but he knew his parents would not understand.

He always maintained, to anyone who would listen, that he learnt his lesson at 6 months. The following two years were spent undoing this lesson, and his life. John spent the next 15 years in and out of prison for petty crimes and drug dealing. His mental health deteriorated

and he was found dead in his flat from an overdose of Valium, heroin and alcohol. He was 33 years old."

The impact that criminal justice interventions, and in particular prison sentences, have on drug users is not part of the master narrative. The use of counter narratives is an aspect of CDT, and is used to highlight that the focus of policy ignores the impact of on the wider drug using population. By creating a story that is based on the amalgamation of different experience, it can provide an insight into the experience of those marginalised by policy. Furthermore, as we saw in the social construction and intersectionality discussion, criminal justice sanctions result in discriminatory practices against marginalised and vulnerable communities, as well as the general drug using population. The fact that criminal sanctions may *cause* the drug problem policy seeks to address is ignored in what I have previously termed 'constitutional side-stepping'. This term is used to describe the response by most government representatives. When asked about criminal justice sanctions, or whether there will be policy discussion on criminal justice responses, the default response is that legislation is reserved to Westminster, therefore there is no control over its implementation. This response is not given when in private discussions, or those governed by Chatham House Rules, which gives us insight into the fact that it is a political response, as opposed to an actual barrier. There are discussions taking place behind closed doors to look into criminal sanctions, including the implementation of initiatives such as *de facto* decriminalisation, but these are not published or available unless you are privy to these conversations, as I was.

Scottish criminal law has always been separate from English criminal law (1707 Act of the Union, Article 21)). As discussed in chapter one, public health responses to drug consumption are devolved to the Scottish parliament. Within the existing devolved powers Scotland has been creative and provides alternative options through the drugs courts (Gallagher et al, 2019), and work with young people in preventing problematic drug use (c.f. Crew, Scottish Drugs Forum, and Health Scotland, 2019). In addition, the breadth of the sentencing structure allows flexibility: for example possession of a class A drug on summary warrant (lesser crime) can be up to 12 months imprisonment and/or a £400 fine, on indictment (more serious crime) 7 years imprisonment and/or a fine. However, this flexibility in itself is wrought with inconsistencies, and dependent on the actions of the prosecutor on deciding summary or indictment, the opinion of the Sheriff or Judge, and the character of the defendant. This makes the implementation of national strategies such as promotion of health based alternatives to imprisonment very difficult to achieve. Further, following the introduction of two pilot schemes in England that sees individuals found with small amounts of drugs either let off with a warning, or diverted to a third sector support providers[35], it is clear that strict interpretations of the MDA 71 are not required. If Scotland chose to be flexible

[35] See further Thames Valley Police initiative at https://www.thamesvalley-pcc.gov.uk/police-and-crime-plan/performance-overview/reducing-reoffending/substance-abuse/ and the Durham initiative 'Checkpoint' at https://www.durham.police.uk/Information-and-advice/Pages/Checkpoint.aspx

in its implementation of the Act, there are ways in which low level dealing such as subsistence dealing[36] and social supply[37] could be treated without a prison sentence.

Currently in Scotland, drug offences make up 24% (6233 people) of all recorded crime (Scottish Government, 2019a). Of this 16% received a custodial sentence with an average stay of 2 years. A further 24% received a community sentence, and the bulk of convictions (42%) were a financial penalty. There has been limited research to date that looks at what impact interaction with the criminal justice system has on drug using patterns (Hayhurst *et al.*, 2017), or the impact that criminal justice sanctions have on drug using populations, and most of that is based in North America. Generally speaking research focuses on whether interventions increase risky drug use such as injecting (for example Strathdee et al, 2015), the impact on HIV prevalence (Altice et al, 2015), or the racial disparities in the US system (Beckett, 2006; Brunson & Miller). The association between drugs and criminal justice interventions often focus on the role drugs play, and whether drug use or recidivism increases/decreases after engagement (for example Jennings *et al,* 2020, Babor et al, 2018, ch.11). However, the more nuanced understanding of the relationship between drug use and criminal justice interventions is still to be done, and using a CDT framework may help to re-focus away from the narrative of drug harm, onto the narrative of policy harm. For example, my experience as a support worker showed me the huge impact court fines can have on drug dependent individuals. More often than not these individuals have no other income other than state benefits, and this income goes to fund their addiction – be it alcohol or illicit drugs. Fines do not prevent this, and clients would often be in arrears and threatened with custodial sentences as a result. I have witnessed anxiety, panic attacks and extreme drug taking, mental health deterioration, life chances ruined and death that resulted directly from the stress of being involved with the criminal justice system. While this thesis cannot cover this topic in depth, it is an important area that should be explored further in future CDT research.

Contrasted with this, 27% of the Scottish population reported ever using illicit drugs in 2018/19 (1,429,650), with 7.4% (391,830) reporting that they had used in the last 12 months. The most common drug was cannabis (70%) closely followed by illegal prescription drugs (34%), cocaine (19%) and ecstasy (13%). Heroin is recorded as being used by 1% of the population, remaining stable in comparison to previous years (Scottish crime survey 2018/19). The low recorded rate for heroin use may be more reflective of the type of drug user (less likely to engage in institutional data collection research), than actual use. What this highlights is that there are a lot more people using drugs, than being prosecuted by the courts, and this is supported by previous research that estimated there were 3000 cannabis users for every 1 arrest (Nguyen and Reuter, 2012) and more recently 5,500 users for every arrest (Caulkins et al, 2016).

[36] This term describes dealing that is undertaken in order to supply the dealer with her own drugs, and no more.
[37] This term describes James' predicament, being the main contact for several social groups and buying drugs but not making much profit from it.

The main reason that the master narrative of problem drug use persists is that it clearly illustrates the risk of harm that can result from drug use. The counter narrative provided here shows the risk of harm resulting from criminal justice interventions, and develops the rationale for a critical drug theory. By using personalised stories to focus attention on the silenced or ignored aspects of drug policy, CDT can inspire empathy and compassion towards those experiencing this silencing, and thus affect change.

The following narrative is a meta-narrative: a fictional story that seeks a middle ground incorporating enough of the main stories to provide consistency, credibility and coherence allowing for an alternative viewpoint. It combines John and Barry's story to explore what may have happened if our legal and social relationship to drug use was different: i.e. if we implemented drug policy reform as advocated by many drug policy activists and workers.

Historical Legacies Meta Narrative: reducing the harm of drug policy

Barry and Jamie had known each other for years. They had been pals in primary school but in high school they had drifted apart. Barry was a small shy boy, and the target of bullies. He often came into school with bruises and dirty clothes: no-one really knew who his family were except to steer clear from his uncle. Jamie on the other hand sailed through high school. He had a supportive family, a good circle of friends, and despite the poverty surrounding him, he had aspirations of leaving school and getting a good job. It was 1986 and the factories were closing down around them. Barry had finished school a year ago, and he had just lost his job at the yard. The last year had been hard as he watched his dad sink deeper into an alcoholic depression, and the black dog of depression was hanging on his own shoulders most days. One day, as he was walking the streets aimlessly, he bumped into his pal Neil who asked whether he wanted to come up to his and try some smack. They'd had drug education in school, and he'd heard that smack (heroin) was a good painkiller but that it was potentially very addictive. He knew he felt shit, he knew he'd like to take something to stop himself from feeling like shit, but he didn't want to get into something he would have to rely on for the rest of his life. Knowing all this he said 'nah, you're alright. How come you into that stuff man?' 'Ah pal, said Neil, 'ken, ah knew it was habit forming but aye, it's just so good, once you try it, it makes you forget absolutely fuckin everything, and I mean everything.' Barry nodded, there was a lot he wanted to forget, but he knew Neil had more he needed to forget. 'Heard you can get a script – pure stuff – from the doc, have you thought about that?' 'Aye', said Neil, 'I'm gonnae start Monday, that and some therapy. They say I've got childhood trauma shite I need to deal wi.' 'Good luck then pal', and Barry was off.

A little while later Barry bumped into Jamie, his old pal. 'Hi Barry man, how you doing? 'Och, no so bad, no so good either to be honest', Barry replied. 'Fancy coming to rave with me, Shaz and the gang', said Jamie, 'It's her 21st birthday and it's gonnea be a belter! Just

off to get the weekend stash sorted. In his drug education Barry had also learnt that ecstasy was not very dependent forming, and the main problem was related to quality and quantity. He was curious and needed a boost. 'Aye alright' said Barry, 'could do wi a bit of a blow out'. Nice one, said Jamie, 'meet at mine the back 'o 8, I'm just heading to Easterhouse to pick up.'

As Jamie left the high rise in Easterhouse he noticed a police car driving past. He hunkered down, didn't want to get noticed. Although technically folk weren't getting done for possession of drugs anymore, he had 100 pills and an ounce oh hash, and he wasn't sure he could swing it with that much on him. The police drove past. They recognised him as a regular at the flat. 'No doubt see him out at the rave tonight eh', said one of the police. The other laughed, 'aye, giving a huge hug and snog to any polis in the vicinity most likely'. The police knew that Mark was dealing ecstasy from his flat. They also knew he imported the ecstasy from Holland on a monthly basis. But they also knew that the harm caused from this activity was nothing compared to what they were dealing with in and around the local pubs, and they would rather have the local teenagers munching on ecstasy in a field, than beating up their neighbour down the pub.

Barry had a fantastic night. He danced and danced and hugged and loved and came away with 20 new best pals. Jamie and him started seeing each other as friends, and gradually they moved from clubbing and working in bars, to other more 'professional jobs'. 30 years later they have 3 kids between them, and still hook up for the odd pint or smoke. Occasionally they enjoy a line of coke together but nothing on the scale of the old days.

I have tempered this story to include only policies that are possible within the current structures. It is possible to give comprehensive drugs education that tells young people about the enjoyable and negative effects of drug use. It is possible to prescribe heroin to people who have become dependent on heroin, and it is possible for the police to implement a non-arrest policy for low level drug possession and dealing. Indeed, back in the late 1980's early 1990's, police hauls of ecstasy were relatively low, and policing of the activity was limited. One of my interviewees was a drug squad officer for Strathclyde at the time:

"…[W]e didn't see it because the people who are taking it and the people who are supplying it just didn't come onto the criminal justice radar. We were busy with car thieves, house breakers, serious assault, gang leaders, there was a huge gang culture, I mean part of it was just running with the gang and dishing out vicious vicious serious assaults, like horrible stabbings and slashing and murders, so we didn't see drug users.

…I saw the ecstasy market come from absolutely nothing, and it was all about the club scene. I had one of the biggest recoveries in Scotland which was 111 MDMA tablets that would have been around 1990, the biggest at that time, when I first went to the Drugs Squad. And it was destined for the Hanger 13's scenes down in Ayre, there was a huge rave scene down in Ayre, and that's where they all went. And that's exactly what they were all

doing. They were sourcing Eccies (ecstasy), taking them down there, punting them and that was like your night out, your drugs, and a bit of business as a side line. I was in the drugs squad proper until 1994, and I remember latterly 600,000 ecstasy tablets in a concealment coming in from Belgium and I took them out and they were concealed in a van" (Ex Scottish Minister #1).

One reading of this meta-narrative is that my own personal bias towards psychoactive drug use (as opposed to opiate drug use) is being used to illustrate how different drug using choices can impact future life chances, but that was not my intention. While there is a discussion to be had outwith this thesis on whether involvement with psychoactive drugs instead of opiates does indeed impact life chances, the intention here is to present multiple potential outcomes to the master narrative, in order to show how policy could be implemented, with different results.

What we can see with these three narratives (master, counter and meta) is that they all speak to different developments of policy, and in particular how policy has, or could be, enacted over the years. In this way these stories provide evidence for the development of CDT, by highlighting the concepts underpinning drug policy, and how these concepts could be different if the underlying premises were challenged, and changed. As Swedberg (2012) notes:

"To do science, according to Pierce, means among other things to challenge existing signs and concepts, and to show how these have come into being; how some elements of reality have come to be cast as this particular concept rather than as some other concept" (11).

Stakeholder Participation in Drug Policy

The following narratives are about the kind of drug users considered legitimate (or not legitimate) stakeholders in policy participation. The narratives here are made up of numerous personal stories I came across during the data collection period: interview data, engagement in the policy process through advisory groups and committees, combined with my background knowledge of the kinds of drug using communities in question, and the official focus of policy taken from documents such as the Road to Recovery (2008). As developed in chapter 7, there are different typologies of stakeholders: the sick, the recovered, the professional and happy drug consumer. These narratives explore each of the typologies but combine both the sick and recovered into one narrative, and the professional and happy into another. The final meta narrative combines all four.

Participation Master Narrative: The Sick and Recovered Drug User

This narrative justifies why those with lived and living experience should be part of the policy process. The narrative is similar to the representation of the problem (Barry's story), except it is more focused on the recovered/sick person participating in policy advisory.

Debbie stuck out her hand to hail the cab. The rain was lashing down and she'd be damned if she was turning up to the group soaking wet and late. This was her second meeting with the Scottish Government PADS committee, and she was nervous. As the taxi crawled through the city center, heat on full, wipers sloshing the rain away, she reflected on how she'd come so far from the streets of Glasgow.

10 years ago she would never have thought, in her wildest dreams, that she would be one of what she used to call 'the grey people': moving through streets in taxis, attending meetings and making a difference! 10 years ago she was living hand to mouth, sometimes on the streets, sometimes in hostels, always on drugs. How had she ended up on the streets? She'd told the story countless times now, so often that it had become a story separate from her in some way.

Her early life had been hard. Her mum was a single mum with three kids, dad had fucked off when she was 3, couldn't handle her mum he'd always said, but Debbie now knew it was because he couldn't handle his own drug and alcohol problems, and family life was too overwhelming for him. Her mum had tried to cope, but she had her own drug and alcohol problems, and a series of abusive relationships with men who also abused Debbie. At 13 years old Debbie was removed from her mum because the school found out about her mum's drug problems, and the abuse that Debbie was being subjected to by her mum's boyfriend at the time. She often wondered what would have happened if the school and social services had actually supported her family, rather than separate them. But that was history.

She was 15 when she tried heroin for the first time. She'd used plenty of other drugs, alcohol, fags, cannabis and speed. She enjoyed the feeling of getting high, it took her away from the immediate situation and pain. When her pal Neil offered her a smoke of this black sticky stuff she didn't think twice. Yes she'd heard of the dangers of heroin, but she enjoyed drugs, and didn't believe the hype. The first time she tried it she didn't like it. It made her vomit and itchy, and she didn't really get a high. However, Neil told her you need to take it a few times before you get the proper effects, so, curious to see what the 'proper effects' were like she did. Neil became her boyfriend, and seven years later and she's living on the streets, surrounded by her drug using community.

But here she is now, 17 years later, on her way to an official government meeting on drug related harm. The 'lived and living experience representative for the drug harm and death committee'. How in the hell did she turn it around?

"We're here pal". The taxi driver's interjection breaks her reverie. She hands him the cash, asks for a receipt, and jumps out. Deep breath, and relax, 'I've got this' she says to herself.

She's early, so she sits down to wait for the government official who will escort her through St. Andrews House to the meeting room. Her mind wanders. What's she doing here, what value does she add to these meetings? Sometimes she feels like the token ex drug user in recovery, in a room full of professionals, everyone talking about service users and problem drug users. Is this her role? To provide them with the user experience? But what is her experience?

10 years ago she started her journey of recovery. She had been in and out of treatment for several years, never really engaging with the services because she didn't feel they had anything they could offer except the insistence that she stop using drugs. She didn't want to stop using drugs. She liked the feeling they gave her, loved her drug using pals, and couldn't see how she could ever change the situation she was in. Yes her health was suffering, she had been in trouble with the police on many occasions, and experienced some horrible situations with so called friends, and had no home. But it was all she knew.

Then one day she was approached by a support worker from one of the recovery groups. They offered to support her getting off the streets and onto a methadone prescription and stable housing. It was auspicious timing because she had just lost two of her close friends to overdose and contaminated drugs, and her partner Neil had spent a stint in jail for drug dealing and assault, and was not due to be released for another few years. She was paralyzed with fear about her own life chances. Over the next four years she gradually stopped using street drugs and stuck to a prescription. She found support from the local recovery cafe and a new community was shown to her. Eventually she went on to complete the LEAP recovery programme, an abstinence based programme that supports individuals and families through their recovery from drug dependence.

'So I guess this is why I am here' she thought. So I can tell them my experience, and the experience of my community and what worked for us.

As we saw in chapter 5, the archetype of the legitimate stakeholder is one who has lived or living experience of problematic drug use, in particular opiate and benzodiazepine use. This includes family members and significant others who have been impacted by problem drug use. The recent commitment to meaningfully engage with this community is to be welcomed (Scottish Government, 2018), and I struggled writing the counter/meta narratives because I did not want to dismiss the importance of including those most affected by drug related harm in policy decisions. Yet, as previously argued, the concept of drug related harm is complex, and while improvements in engagement have taken place, there is still dissatisfaction by many with the way that participation is being carried out, and the silences and sidestepping in regards any other kinds of drug use and participation.

In this section Debbie's story is the master narrative: the problematic drug user who has a history of trauma and dependency but is on the road to recovery. The counter narrative explores the silenced drug user: the person who enjoys using illegal drugs, does not engage with any treatments service and has minimal harm stemming from their drug use.

Participation Counter Narrative #1: the professional and happy drug user

In the previous chapter the WPR analysis identified one of the silences within current drug policy narratives as being the happy drug user. The challenge for a drug policy that is focussed on drug harm is where does this voice fit in?

The following narratives use the characters from our historical legacies narratives. I do this in order to bring coherence to the narratives, and so that the final meta narrative can link all four characters, Barry, Jamie, Neil, Shaz and Debbie in the meta narrative for participation. The unequal gender spread of my characters is reflective of the unequal representation I witnessed during the data collection period, however I did not incorporate a specific gender element into the thesis. Interestingly, over the 5 years I have been engaged at a policy level this has started to change, as more women enter the policy space.

There are 3 narratives in total. The first two narratives are based on the professional, sick and happy drug user, one from within an institutional setting, and one from outwith. This is because I came across these narratives constantly, and are reflective of the wide range of drug using experience in society. The last narrative is based on the 'sick' drug user: the perceived 'problem drug user' who is 'sick' and needs help.

Jamie trudged to his desk in St. Andrews House. Monday mornings after a mental weekend can be brutal. He didn't go out much these days, what with the kids and the job and that, but it was his pals' 40th birthday and she had organised a weekend away in the woods with the old crew. It was a belter of a weekend, reliving the good old days of dancing, MDMA and mushrooms, old skool techno and singing round the fires. Every time he had a weekend like that he spent the next few weeks with a heart full of love and reconnections. Back to the grind though.

He had been working at the Scottish Government as a civil servant for the past 12 years, and had recently moved to a new policy team – the Drug Policy Unit. He had seen the post come up, and given his personal experience of drug use thought it would be an interesting post. However, he was beginning to realise his personal experience was not something he could share with colleagues on the team. He'd never been open about his drug use with work pals. He smoked a bit of dope at the weekends, and had the odd party each year, but his socialising with work colleagues went no further than the annual Christmas bash, and the occasional pint after work. It was never an issue, but coming to this post he had begun

to get frustrated that he couldn't be honest about his experience. Every day he was seeing things that contradicted his experience as a drug user. They talked about the rise in cocaine use as if that was some kind of phenomena – christ, his social circle had been using that stuff for decades, and they were not all posh bankers! And the language, it was all about problem this and problem that, and how will we get people off drugs, no recognition that most people use drugs because they enjoy them, or are using them to self medicate deeper personal or socially constructed issues.

All the folk he had witnessed slide into so called problem drug use had done so because of underlying issues. Barry, his old pal from home, had a stint on the smack, but that was because he grew up in a household that was full of violence. Mark, his old dealer, ended up hooked on Valium and heroin after he got sent to prison for dealing. Shaz had a stint with the coke, but she had always had problems with social anxiety, and she got off it without any help. And then there were the usual car crashes, people who just took it too far. But overall most of the folk he knew outwith work had used drugs for decades, and were none the worse for it. In fact he would argue that using drugs like MDMA and mushrooms improved people, made them more open and understanding of the different kinds of realities that exist.

And so here he is, another Monday morning, and a raft of meetings throughout the week with a focus on how to increase the lived and living experience of drug users in policy making, and he can't say a god damned word.

The frustration for Jamie is his inability to meaningfully take part in the development of policy around his own life experience. Although this is a unique position, there are not many people working at the policy unit, it is reflective of the wider frustration felt by many professionals working within institutions, and their inability to use their own drug using experience in discussions on drug policy or engagement. As discussed above, the criminal nature of the act prevents open discussion, in addition to the stigma attached to drug use.

The second narrative is about engagement from outwith an institution, and focusses on the gatekeeping that can take place in order to restrict certain voices from being heard at a policy level. I introduce a new character here, Catherine, who is from a middle class background, low ACE score, and a regular drug user since her early teens. She combines the 'professional' and 'happy' drug user typology, and this fictional character is representative of many non-institutional actors attempting to engage in the policy process. This narrative also expands on the story of Shaz, who we met earlier as a friend of Jamie's, and who combines the other 'sick' stakeholder – using drugs for medical reasons, and 'happy' stakeholder.

Participation Counter Narrative #2: The professional and sick drug users

Catherine put her head in her hand, and thumped the desk with the other one. What was it with these people?! She had been organising this event for weeks and then one wee news article where one of the participants criticised the government and the civil servants' response to the drug crisis, and boom, they pull out. The article had also focussed on how the government were obsessed with drug harm, and refused to acknowledge the wider drug using population, specifically calling out the unit for not allowing engagement on other issues such as drug testing in festivals and clubs. It had also talked about the use of drugs for medicinal purposes such as cannabis, and using psychedelics to treat opiate dependence, which wasn't that controversial, was it? And what were they afraid of anyway? Surely it was better to be round the table even if you didn't agree with everything that was being said?

She took a deep breath and sighed. It was fucking classic. So many non-institutional organisations and people were keen to be involved in policy making, especially at the agenda setting stage, but it seemed impossible to get past the gatekeepers. If you weren't singing the song of recovery, or god forbid were challenging the effectiveness of recovery for some people, then you were locked out of the conversations. She'd even heard rumours that the reason the policy advisory structures had been disbanded was because they were too challenging and called for more radical reform such as drug decriminalisation.

The event that Catherine was organising was a multi-stakeholder event for people who use drugs. Shaz, her co-convener was an expert on putting on large events. Catherine had known her since their clubbing days in the early 1990's, and her free parties had always been the most well organised of the lot! Now she was a professional events manager and they were working together to put an event on that was close to both their hearts.

Shaz had seen her fair share of drugs. Growing up in the '90's she'd been a regular clubber, and in her and 20's she developed a problem with cocaine. Her 'problem' had been she just enjoyed it too much. It made her feel invincible, and countered the social anxiety she had felt all her life, despite coming from a loving and generally stable home. However, too much of a good thing can have devastating impacts, and her mental and financial health had suffered. She'd pulled herself back from the brink thanks to good friends and an understanding she was taking it too far. Her therapist had said she probably developed the anxiety from being over-protected: her mum had always been a 'nervy' character. In her 30's she was diagnosed with M.S., and after several years of trying different pharmaceutical drugs that did more harm than good, in her opinion, she became a regular cannabis user. It worked wonders for her, and as a result she had become an active campaigner in the reform of cannabis, both for medical and non-medical uses.

So Catherine and Shaz were collaborating on this event, and it was a big deal. The idea behind the event they were organising was to broaden stakeholder engagement in policy making, and they had worked hard at developing relationships with the policy community

so that they could feed back the outcomes of the engagement, and hopefully get some meaningful participation in policy at a higher level than just 'consultation'. But, they had been warned from an early stage, by all parties, institutional and non-institutional, that engaging with the government would result in being let down. They had paid lip service to user-led engagement for years, and they weren't about to change, they said. I guess they were right, Catherine thought.

Initially her engagement with the policy makers had been positive, easy even. There were good communications, private chats, meetings and the sense that collaboration was developing. But somewhere along the way that had changed. Maybe it was when they realised she identified as a drug user, maybe it was when those who she collaborated challenged them about their lack of engagement, or maybe it was her links to more radical aspects such as calling for drugs such as MDMA and psychedelics to be used in a medical setting. Who knows. All she knew was the door was firmly closed, and she had an event in two days time with the aim of creating links between the policy makers and stakeholders, and one of the parties were not going to be there.

This story is about the experience of non-institutional actors who have tried, and often failed, to get their kind of meaningful engagement from policy makers. It shows that when exploring the oppression and marginalisation of drug consumers using the narrative arm of CDT, other aspects of CDT can become intertwined. For example, while much of the policing and focus of institutions is on a demographic of drug users that are part of other marginalised groups by poverty, race, mental health, etc., the impact of policies cut through many layers. Given her position within the professional world intimated here, there should have been little difficulty with her being able to pull in a wide range of stakeholders. However, it is her perception, however 'real' or not, that she is being prevented from accessing the policy engagement because of transgressions, such as being open about drug use, or being critical of the government. The exposure of her as a drug user has resulted in her becoming a marginalised person, in this instance at least, and highlights how the stigma towards drug users has a chilling effect on meaningful engagement regardless of social positioning.

The third counter narrative to participation focuses on the 'sick' stakeholder, the person with living experience of drug use who is not engaged in treatment, and indeed may never be ready for the kind of treatment being offered.[38] However, it also encompasses the 'happy' stakeholder, as the character appears to be content with his drug use, despite it being injecting opiate use, which is the focus of the harm narrative. Furthermore, this is the kind of stakeholder that is being encouraged to engage in the 'living experience' consultations, in order to give the Scottish Government, and treatment services a better understanding of barriers to treatment and recovery.

[38] Heroin Assisted Treatment, although available to the Scottish Government to implement since the Scotland Act 2012, was not put in place until the end of 2019, and therefore does not feature in the counter narrative

This story is slightly longer as it requires an element of setting the context, and apologies in advance for the swearing!

Participation Counter Narrative #3: the sick and happy drug user

Neil peeled open one eye and squinted. The sun was blazing through the flimsy curtains, hurting his eyes but warming his body. He felt the glow spread from his legs up, the warmth of the summer sun slowly penetrating his skin. A cloud covered the sun and his body chilled, ah, time for my morning fix he mused. As the kettle boiled, he rolled a joint and started to set up his kit[39]. He only had enough left for today, he would have to go easy on his stash 'till his money came tomorrow, he didn't have the stomach for begging today. As he sipped his coffee and started to heat up the spoon his phone rang.

'Hullo?'

'Neil, it's Debbie…'

Neil paused. Debbie.

When he had come out of prison he had looked for her on the streets, and local doss houses they had been known to frequent over the years, but she had gone. Word was she had entered into an abstinence based rehab centre, and not been seen since.

'Oh, hi. Long time no see eh. How'd you get ma number?'

'Och I bumped into Barry, and he said he'd seen you a few years ago, got your number. I know it's weird me calling, I just felt it was time to reconnect. How you been?'

'I'm okay I guess. Got out a few years back, got a job, stayed off the smack, lost the job, got back on the smack. You know how it goes. But I'm actually okay. I've got a flat, benefits paid for, seem to be able to hold it all down. I'm not using like we used to, I like to spread it out now, ken, a wee starter in the morning, one mid afternoon and then an evening relax. Didn't get back into our old crowd though. After coming out of prison and getting a job I started seeing the world differently. Remember when we used to laugh at the 'grey people' (both laugh), well now I dinnae think they're so bad after all. Life catches up with you eh.'

'Yeah, funny, I had that thought this morning on my way to a 'grey person' meeting.'

'So what you been up to? Heard you went full abstinent, no contact, that sort of thing.'

'Yeah, I had too. It was all getting too much, thought I'd end up dead or in prison like yourself.'

They chat for wee while, catching up, exchanging stories about past lives and friends. Then Debbie asks 'do you ever feel you want to get off the smack and the dope? I mean, you been on it so long, do you not wonder what life is like without any kind of drug?'

Neil laughs. 'So this is when you start coming over all righteous eh! Am I one of your conversion targets? Peer outreach, that kind of shite?'

'Och, don't be like that. No, the opposite in fact. Barry had said you were doing good, got your flat, got a wee routine, but still using. I wondered if you wanted to get involved with a

[39] A term used to describe the various items one needs to inject heroin.

group that's been set up to get folk with lived and living experience of drug use involved in drug policy?'

Neil was interested. His days were spent roaming Glasgow, attending job seeker appointments, getting his wee bags of heroin, and watching Netflix, so he was up for something a bit different. And Debbie had said the group were not looking to recruit folk into treatment, but get people who are currently using drugs to talk about what works for them.

The meeting was being held in some old council buildings, recently done up, but still with an air of fallen grandeur. As he sat at his allocated table with 6 other people he looked around the room. Everyone looked so normal! He'd had his morning fix, and smoked a joint before walking in, but he still felt anxious. What the fuck was he actually doing here. Who were these people?

'Welcome everyone' said the lady at the front. She then proceeded to outline the focus of the event. 'We want your feedback, as people in recovery with lived and living experience of problematic substance use, to help us design treatment that works for you. As you know, the Scottish Government are committed to including your voices in the design and delivery of services that you access. Therefore your views matter.'

She waffled on for a few more minutes but Neil had heard enough. Soon as he could he was gone. Who the fuck was she to tell him that he had 'problematic drug use'. He'd never managed his drug use better in all his life, and that was no thanks to any of the services he'd been put in touch with. All he'd got from them was opinions. Opinions on how he should behave, opinions on whether his use should stop, opinions on his life. Nut, he was fine on his own thanks. The only way that they could help was to give him his medicine for free so he didn't need to use his benefits to pay for it, or risk jail. But that wasnae gonnae happen. He'd heard that Glasgow were starting heroin assisted treatment, but they were for folk who had gone through the system, were on the streets, were basically near death's door, and he' be fucked if he was going to return to that state just to get his stuff for free.

He felt the anger bubble up inside him. He looked round the table. Everyone staring intently at the speaker, nodding in the right places. At some point the lady stopped speaking and his group turned to the table and started talking. He'd missed what they were meant to talk about. 'We're to talk about what matters to us, what would work to help us on our journey towards treatment' said a lady at the table.

He stared at them. 'Personally I'd just like to get access to ma heroin from the doc, so I don't need to spend so much money myself, and don't need to risk the jail every time I pick up. That's what would help me'.

They stared at him. 'So you're not interested in the different treatment options, or have any suggestions on how they could be changed to make you feel able to access them?' asked an older man to his left. 'what about getting off the heroin altogether? I mean surely you're not happy taking it every day? I stopped 7 years ago and it was the best thing that ever happened to me'.

'Good for you pal', said Neil, 'but nut, I'm perfectly happy with my level of drug use the now. I'm not on the streets, I'm not using dirty needles, I got a nice wee flat, I'm perfectly happy, until I'm not. It's the reason I've never engaged with any of this shite, because there is always the underlying assumption that I am using but I don't want to. How about I just want to continue with what I'm doing the now, is there help and support for that?'
'I don't know how to record this as an outcome, it's not really related to the treatment question' piped up another person at the table.
Neil pushed back his chair. ''Enjoy yourselves' he said to the group, 'I'm off for a smoke and then my late-afternoon hit'. He winked at the table and turned and left. Bag 'o' shite he thought as he left the building.
He walked slowly along the street, taking long puffs on his joint. The sun was setting and deep red and golden streaks poured over the sky like a luxurious bedspread. The birds were singing their evening song and life was good. He smiled. If anything that meeting had confirmed to him he was happy, but he'd never engage in that government shite again.

The main aim of Scottish drug policy is to reduce the harm from 'problematic substance use' by encouraging people into treatment. In 2015/16 it was reported that approximately 57,300 individuals (1.62% of the population) in Scotland were using illegal drugs problematically (NHS Scotland, 2019). Contrasted with the statistics that show in 2018/19, 10,757 initial assessments for specialist drug treatment were completed (Scottish Drug Misuse Database, 2020), we can see that a sizeable amount of 'problem drug users' are either not initially engaging, or do not continue to engage. This focus on treatment is what prevents many people seeking support for their drug use, either because they feel they do not want to stop, or there is a distrust of the institutions spurred by the stigma associated with using drugs. As we saw with the LLEEG discussion, many participants felt anger at the continued focus on medical solutions to what many of us consider social 'problems'.

Neil's narrative reflects the feelings of many drug users: that to be involved in any service or institutional advisory body, it will be assumed that their drug use is something they wish to stop. However, as this counter narrative explores, many drug users are content with their drug use, or at least do not regard their use as harmful enough to seek treatment. Furthermore, many people who have engaged with the treatment system will do no so again, feeling that they have been treated with stigma and had a medical narrative imposed on their drug use (LLEEG insights). Over my life, and throughout the data collection period, I met people who had experienced episodes of harmful use, but 'recovered' without the help of services. Often there is a wariness of engaging with institutions that have not been seen as advocates of drug users, and this is reflected in Niel's guarded response to being involved at all. Furthermore, as the narrative highlights, often when current drug use is brought within lived and living experience stakeholder groups, there is an assumption that it is something one is seeking to stop, but unable to do so. This assumption is based on a measurement of harm, as discussed in chapter 8. The assumption that drug use is

harmful guided most of the dialogue in the institutional settings I was involved in, and it was not until less formal settings such as the SDPC emerged that some people felt able to vocalise their opposition to this assumption. In fairness this obstacle has been taken into account in the 2018 Scottish drug strategy, with an emphasis on people finding '*their own kind of recovery*"'(Scottish Government, 2018, 4) in the community. However, a strong feeling from some of the participants within the groups I was involved in, was that the focus of participation is so heavily directed towards recovery and treatment, it fails to take into account other aspects of drug use, in particular the pleasure that most purport to experience when using.

We now turn to the final narrative – the meta narrative of participation. To re-iterate, the meta narrative is a fictional story that seeks a middle ground incorporating enough of the master and counter narratives to provide consistency, credibility and coherence, allowing for an alternative viewpoint. To an extent it is an idealised account of what could happen, and the in keeping with the storytelling aspect of this chapter, the narrative explores the different characters and their experiences, as opposed to the mechanisms of participation.

Participation Meta Narrative: everyone feels listened to and engaged

In an ideal world all stakeholders feel meaningfully engaged and are able to participate at all levels of the policy making cycle. However, as the research shows this is often not the case. The background to the following narrative is an event that has been put on by an independent stakeholder advocacy group, with the backing of the Scottish Government, to discuss drug policy reform. This event is fictional and I use this setting – a large stakeholder engagement event – to explore each character and what meaningful participation means to them, and whether it can been achieved within these settings.

Because the characters circumstances have, in some instances, altered throughout the narratives to reflect different possible outcomes, I clarify which storylines I am using for this narrative:

1. **Barry** – Violent family, exposed to poverty and drug use early, long term opiate dependency and, despite accessing services, he continues to use both prescribed methadone, street heroin and cannabis.
2. **Jamie** – Supportive and loving family, yet family suffered from high levels of poverty. Exposed to drug use at a young age, never had an opiate dependency, didn't go to jail for his drug dealing, but instead used drugs regularly and has worked at the Scottish Government for the past 12 years.
3. **Neil** –violent and sexually abusive yet financially secure family, Exposed to drug use in teens. Opiate dependency for several years but then stopped. Started using heroin again but is stable, uses cannabis as well heroin on a daily basis.

4. **Debbie** – Violent and sexually abusive background, history of care, long-term opiate dependency, now in abstinence-based recovery and part of the lived and living experience advisory structure of the Scottish Government.
5. **Catherine** – loving but unstable family, middle class but not financially secure background, used illicit drugs since her teens, never developed an opiate or other drug dependency but continues to use cannabis, psychedelics and psychoactive drugs from time to time.
6. **Shaz** – loving, stable and financially secure family. Used cocaine extensively in her late teens/early twenties, stopped using in her mid-twenties. Diagnosed with M.E. and now vapes cannabis on a daily basis and uses psychedelics for spiritual/therapeutic reasons.

Catherine stepped out of the shower, grabbed the towel and scuttled to the bedroom. It was extremely early on a cold November morning and the heating hadn't kicked in yet. Nevertheless, she was feeling exhilarated and happy. The first day of the stakeholder event entitled 'Deliberating Drug Policy in Scotland' had gone smoothly, and today was the first day of proper deliberative discussion. She smiled as she remembered Shaz's ecstatic mood last night. 'We did it' she had screamed at her down the phone. Shaz had left early, childcare emergency, but everything had been coming to a close, and Shaz's main job had been to make sure the event had run smoothly from the beginning. Her mum was looking after her son today, so no childcare issues on the horizon.

Catherine dressed, went downstairs, and made herself a coffee. She resisted the urge for a cigarette, for now at least, although she was finding it increasingly difficult to do that at the moment. 'Must be the nerves' she thought. It had been a long slog getting this together. Shaz and she had been lobbying for a deliberative process on drug policy in Scotland for years, and there had been many a time that they had almost thrown in the towel. It was difficult working with institutional actors and activists: so much tension, anger, defensiveness and lack of empathy and understanding of other people's concerns or needs. However, they had been successful in convincing the Scottish Government to give them funding to put on a large stakeholder engagement event to set the groundwork for a Citizen's Assembly in the future. It was sad but the reason the government and other institutional actors were interested was because of the increase in drug related deaths, and the media focus that continuously called out all institutions for not engaging with the public better on what they actually want drug policy to look like. 'I won't lie' thought Catherine, 'this strategy of media/activism/behind closed door negotiations seems to work'. 'I may not enjoy playing different fiddles, but it gets them to the table, and that, in the end, is what matters'. She sighed. 'Once this is all over I am becoming a gardener I think!'

As she entered the conference centre the participants were filling up the hall, each had been allocated a table mixing up the 120 different stakeholders invited, and there was a soft burble of chatter as they settled into their seats. Yesterday the Minister had introduced the

event, and made it clear that any outcomes from this event would be fed directly into the development of policy. Catherine knew this meant a lot to those involved, particularly those who had been invited as lived and living experience participants, and those who had been involved in the drug policy scene for a while. She, along with many others, felt slightly cynical about the Minister's promise, time would tell, but the fact that this was even taking place was a huge step, and it was supported by a range of respected institutions. This promise by the Minister, and subsequent discussions on how the event would be carried out, respectful dialogue commitments, and a couple of presentations from experts, had created a hopeful energy amongst the participants, and you could hear it in the room this morning.

Shaz came up to her and whispered in her ear 'I'm having a total fucking nightmare. My mum is really not well and can't take Euan. He's going to have to sit in the corner and play the ipad as it is too late to get anyone, and it's a Sunday. Catherine turned to her. 'This is where we messed up. We should have had onsite childcare, why didn't we think of that before? It's one of the main findings in regards community engagement!' They looked at one another. 'Next time we will, but for now this is the only thing that has gone wrong, so let's keep it that way. Euan will be chuffed to play all day anyway', said Shaz. Catherine smiled, always the positive one, must be the illegal meds. She chuckled as she glanced round the room, her eyes resting on Jamie, her old clubbing pal, and she nodded and smiled in his direction. 'Must chat to him before the day is out' she reminded herself.

Jamie looked up. At the front of the room he could see his old clubbing pal about to begin. It had been shock to meet her yesterday. They had exchanged emails several times, but her second name had changed so didn't realise it was her. They had known each other through mutual friends in the West Coast clubbing scene, she had been Shaz's pal mainly and they spent that time at raves and after parties. It had initially scared him when he saw her, what if she outed him about his past drug use? Then he realised that outing him would out her, and he relaxed. He caught her eye, she smiled and nodded, he smiled back. He'd make a point of getting a chat with her today.

He looked round his table. There were 9 other people at the table, and he vaguely recognised one woman whose name tag said 'Debbie'. He felt out of place. It's not that everyone here was a drug user, there were also representatives of different organisations, and people with lived and living experience. He was here as a rep of the Scottish Governments drug policy unit, but he felt odd about it. Why couldn't' he use his own experiences and opinions here, 12 years a civil servant and this was not the first time he had wondered whether he had made the right 'career' choice. He glanced round again and smiled at his table. The lady he vaguely recognised smiled back.

Debbie's stomach churned. She hated these kinds of events, they made her feel nervous and small. She didn't know what to say, everyone seemed to know who they were, had 'qualifications', or at least seemed comfortable in their own skin. It was these kinds of situations that made being in recovery difficult. If she could just have something to take the

edge off… But she couldn't. She took a deep breath. The Convener has started so she tried to focus. Today they would be starting the deliberation on drug policy, and to do that each table were to have a conversation about their initial thoughts on drug policy, in light of the previous day's panellists. This was to set the scene, give everyone an opportunity to start thinking about this before the other deliberative sessions took place. Debbie looked round the table. She vaguely recognised a guy called Jamie, he worked for the Scottish Government but she was sure she'd met him years back, not sure where though.

How many of these people actually had any experience of drugs' she thought, feeling anger rise in her. 'How can anyone speak with any authority unless they've actually experienced it'?

The conversation at the table was becoming animated. Debbie had found her voice, and was talking passionately about drug policy and how the focus should be on getting people off drugs and into treatment. 'I know' she said forcefully' I've been there'. The guy she vaguely recognised piped up for what seemed the first time. 'I totally respect that you have your experience, but maybe not everyone wants to stop taking drugs, or is taking drugs to such an extent that they need treatment. Maybe some people are more damaged by the fact that their drugs are illegal, rather than the drugs themselves'. Debbie stared at him, 'who the fuck was he' she fumed to herself.

Jamie gulped. He knew he should have kept his mouth shut, being a government rep an all, but the conversation round the table was getting heated, and he felt safe enough to put his opinion across without it being attributed to the government. As the words slipped out his mouth he saw Debbie stare at him. 'Oh fuck' he thought', 'now I've thrown the cat amongst the pigeons.'

'And how would you know anything about what drug users want?' Said Debbie, in a cold and angry tone. 'You work for the government. Worse, you work for the Unit, and they are responsible for most of the bloody mess that treatment is in. Why would you say something like that? It's completely irresponsible'.

Before the facilitator had time to interrupt, Jamie replied 'because I am a drug user Debbie. In fact I have used drugs all my life, and many of my pals have used drugs all their lives, and most of them have done pretty well thank you, without the need for government enforced treatment'. There, he'd said it, he held his breath, he stomach did flips and his breathing became tight in his chest. He felt like the whole room had suddenly gone quiet and everyone was looking at him. His face turned a bright red and he waited.

The facilitator looked at both of them, ready to intervene should they decide to continue the confrontation. Debbie suddenly remembered. Of course, how could she forget, Jamie was Neil's friend from school! His face had changed, and he's put on weight, but she remembered him suddenly. It must have been the passion as he spoke, his eyes started sparkling, and she remembered nights in the pub laughing and joking with him and Neil. 'Oh god, I wish I had remembered sooner, then I wouldn't have laid into him'. Instead she took a deep breath and said 'I'm sorry. I shouldn't have made assumptions about your life.

I just get quite passionate, it was a really difficult time for me towards the end, especially when Neil ended up in jail, I thought I would die. I'm sorry'.

Jamie looked at her hard. Neil? He wracked his brain. Oh yeah, Neil, his old school pal. Ended up in prison for dealing heroin, to his pals. And then it came flooding back, the more he looked at her. Yes, she was Neil's girlfriend, for years if he remembered right. They had often spent time in the pub, in between the bouts of serious addiction that her and Neil had. He smiled at her. 'No worries at all, me too. Let's get a chat after the event today eh, would like to hear how Neil is doing'. No-one seemed to have been too shocked at his drug using disclosure: there was a brief discussion on why people used drugs, and some others at the table 'admitted' to using various drugs over the years. Indeed it seemed to lighten to mood, created a feeling of trust between the tables, and set the tone for the whole day. Jamie felt a weight lift off his shoulders, a weight he didn't even know was there. 'I told folk I used drugs, and no-one cared! Wow. I wonder how Neil is doing', he pondered as he returned to the conversation.

Neil turned on his computer. It was 10am on a Sunday morning, cold and drizzly outside. What the fuck was he doing up so early, his inner child shouted at him. It wasn't so bad though, he had his coffee, his joint rolled, and his kit beside him, and instead of watching some inane T.V. show he was logging onto a huge online community about to take part in the second instalment of deliberating drugs policy in Scotland. It was a topic close to his heart, but he usually only got to talk about it with his mates, or on online rants about how shit it was in various forums. This time his rants might actually matter! Yesterday had been a bit boring, lots of shite about respectful dialogue, how the event will be structured, blah blah blah. But he had front row seats, and the video often panned over the participants in the hall, so he had an opportunity to see who was also taking part. He'd been surprised, no shocked even, to see several old pals there. Debbie had given him the link to take part, so he'd known she was involved, but he had no idea that Jamie was a bloody civil servant now, and Shaz and Cat were running the fucking show! He couldn't have made it up himself. Life was weird sometimes.

As he waited to join the video link he sparked up a joint. 'Aaah' he thought, this is how participation works for me. He clicked 'join meeting' but left his video off, for now, no reason folk needed to see him indulging in a wee illegal activity. Anyways, it was just Cat introducing the morning session. The sound of her voice took him back, all those years ago. They were a wee crew for a year or so, he mused, great times indeed. Wonder what happened to Barry? He dropped off the radar not long after leaving school, heard he got into the smack, but hardly saw him since the first time they took it together except for bumping into him a year or so back. Och well, you lose some on the way I guess, he thought, as he turned his attention back to the Assembly.

The community centre in Easterhouse was cold, and as Barry hunched over his cup of hot chocolate, the sadness overwhelmed him. He had been mid-sentence talking about whether he thought heroin should be prescribed to anyone with an addiction, and the pain of the

last 30 years had suddenly hit him. The tears slipped from his eyes. 'I...I...I just wish someone had given me that option 30 years ago' he said in a small cracked voice. 'I know now that the reason I started taking it was I was in a lot of pain, my dad and older brother beat the shit out of me regularly, we had no money so I was always hungry, and I was raped by my brother's friend when I was 11, but I never told anyone. I just started using to numb the pain. If I'd been given the help then, the last 30 years never needed to happen'. His body crumpled. The support worker, Anne, put her arms around him and held him as he sobbed. 'It's okay Barry, we feel your pain'. The others nodded. 'I never really thought about the legality of my drugs' said the person to his left. 'I always just felt I was a bad person for doing it, but I had to do it because it was the only thing that gave me peace. I've seen friends die 'cos no-one wanted to call an ambulance for fear of the police, and others locked up in jail for years for a few bags of heroin. It breaks my heart too to think that all that was avoidable. All because some fucking morally driven politicians can't stomach giving people the medicine they need to help survive. Oooh, this conversation is really making me political!'

That drew a laugh, even from Barry. Everyone knew that 'politics' was usually off the table at these support meetings. However today was different as the organisation was taking part in a thing called, Deliberating Drugs Policy in Scotland, and had agreed to get feedback on certain questions from their service users. One of the questions was 'if you were prescribed heroin at an optimum dose, do you think you would continue to use street drugs?' The answer, it turns out, was probably not, but it resulted in a lot of discussion and ultimately tears, as each person realised their lives could have been a lot different if they had been able to get their heroin from a doctor, instead of a dealer.

As the day drew to a close, Anne came over to Barry and asked if he was okay. 'Aye' replied Barry, 'just taking on board everything we've discussed. It's given me a mind to contact my old pals from the end of school, I started all this with them but lost touch when I got into the smack. I'm still in touch with a couple of them, might give them a call. Thanks by the way, its really good to know that our opinions and thoughts will be taken on board. I've been 'consulted' so many times I can't count, but for some reason this time it felt different. I think it was the questions, they weren't focussed just on treatment, they started us all thinking about the actual framework, questioning the very basis that our current policy rests on, and I didn't even know what that meant 2 days ago'. They both laughed.

Six months later:

'No way, you did not, you total loon'!! Catherine roared with laughter, Neil had just told them a story from one of their days on the street. Debbie laughed 'aye he totally did', and they were not happy about it'. 'Well what about that time you nearly got lifted for dealing in Easterhouse Jamie? That was Shaz'z birthday party, your life would have been a very different one if that had happened', said Barry. 'Yeah, 12 years in jail rather than 12 years in the civil service' Jamie chuckled, 'maybe I didn't get off lightly'. They all roared with laughter.

The six of them had met up at one of the nice café/bars in Glasgow, it had a lovely garden outdoors, and they were enjoying the sun and various alcoholic and non-alcoholic beverages. It had been Jamie's idea, get everyone together. He'd been inspired by seeing Shaz and Cat at the Stakeholder event, and realising Debbie was Neil's old girlfriend had confirmed to him it was high time they all hooked up for a 20/30 year catch up. It had taken awhile. The Citizens' Assembly had used up a lot of time, Barry had relapsed quite badly for a couple of months, and no-one was up for meeting when it was freezing. So they'd set a date in May, and here they were.

'That event you put on went really well eh'? Neil nodded to Catherine. 'Yes, so far so good. We still have a final meeting, and then the report to be written up, but I imagine it will be done by the end of this year. Pretty fast for these kinds of things. Did you feel that you got anything out of it seeing as you were doing it online?' 'Oh aye', said Neil, 'it was great! I got to sit in my joggers, smoking joints, having a hit if I needed, taking a shit if I needed, and feel like I was contributing to some important policy stuff. So yeah, I'd say compared to that meeting Debbie invited me to a few years back it was brilliant'. 'Sorry about that' said Debbie. 'Ocht, it's fine, they learnt their lesson and now have these super birds on the case'. Everyone laughed. 'Yeah, thanks for pushing that' said Barry'. It really sparked some intense chats in our group, but we realised that we felt like criminals all our life because of our addiction, and now we are feeling more empowered to challenge everything. Not everyone is happy with that though'. They all laughed, they all knew what he meant, and they all agreed. 'Well, it just seems our voices are never heard except when they want opinions on how to 'treat' us, assuming we all want 'treated'. I'm just glad we are starting to challenge that, and it's taking place in an official space. So thanks, all of yous' said Barry. Everyone smiled, at Barry and at each other. It had been a difficult 30 years for them all, but they were still here, and it made each one of them warm in the heart to know that change may be around the corner.

When I first started to develop this narrative, I thought I would be developing a narrative about Citizen Assemblies, or other 'new' forms of democratic innovations (Smith, 2009). Yet as I wrote it the story began to take its own path, and explored the characters involvement, more than the setting in which they were in. On reflection I realise that this echoes the content of the research much better: the focus was not on *how* participation was carried out, but whether the participation had been *meaningful.* What the research showed was that meaning depends on many things, and is personal to the individual experiencing it. Therefore, despite there being a strong argument that innovations in the way public are engaged can improve democratic outcomes, including trust in the process (Smith, 2009; Boulianne, 2018), the actual setting for the story was less important, for this research, than the dynamics experienced by the characters. That being said, the way in which participants are engaged will encourage positive dynamics, and the above narrative reflects the research findings on this.

The research explored several different ways to engage, but the most successful, in my experience, were the early SDPC sessions, and the final session of the LLEEG run by the Scottish Recovery Consortium. The narrative above recreates, in essence, aspects of these sessions, including the friendships. I have found, as someone involved in 'drug' scenes since the mid-nineties, a kind of comradery, a glint in the eye that recognises a fellow traveller. And they crop up everywhere! At the same time, well-convened and facilitated stakeholder groups can engender that comradery, there's an energy in the room when people begin to let go of their professional or social personas. When you include the sense of urgency that so many conversations around drug policy possess one can leave these events feeling like you can change the world, and the world will change! Maybe this is not meaningful engagement for everyone, but for many, the feeling that their voice is being heard, and listening to others, is as meaningful as it gets. It also depends on the expectation of the participant. The LLEEG participants were expecting their voices to be heard, and for us meaningful engagement included having our recommendations taken into account when the 2018 Scottish drug strategy was re-drafted. And to be fair, some of them were. But for me, the most meaningful aspect of that event was the relationships explored between participants, and the topics we looked at. The different engagement tools employed encouraged open and honest dialogue, and because with drugs there are usually personal stories involving crime, trauma and often death, there was depth to the conversations that left all of us feeling quite humbled. Alongside this there was a common anger, or frustration, directed towards the public institutions in regards the stigma, discrimination, and criminality that we as drug users have been subject to all our lives.

SDPC on the other hand was never about the outcome: it was a pre-figurative space that was developed in order to explore the question on how dialogue across diverse perspectives can be encouraged, so that the narrative can change to encompass the diverse views, and not just the master narrative. The outcome was to have respectful dialogue and explore drug policy reform. But this created frustration for some too. Mike and I steered the group with a focus on deliberative engagement, respectful dialogue, and setting the boundaries of the discussion from the beginning. As a result most of the conversations we held felt meaningful, to me, and from the feedback I received, to a lot of other participants. Much of it was about being able to express your honest opinion, without the fear of being shot down. Unfortunately this was not always the case, and we lost some participants who felt they could not contribute, but there were times that it worked and created that buzz.

Another aspect of this final narrative relates to the concept of 'horizons' that I discuss in chapter 2. As Waganaar states: "*we are always part of the situation we are trying to understand…we live and understand in emergent time" (*2015, 203). In other words, as we experience our reality, shifts in perception result in new understandings, and a new reality. In this narrative Jamie's disclosure of drug use results in no condemnation, something which he was expecting. As a result, his structural reality shifts – he realises that his drug use disclosure is not an issue, and a weight falls off his shoulders. His structural reality changes as he realises he does

not need to hide his drug use anymore. The narrative also shows how his disclosure results in those around him expanding their horizon: they 'admit' their own drug use, there is a feeling of honesty engendered by the disclosure, and this carries on throughout the day. This changing of perception, the expanding and fusion of horizons, is common in well facilitated drug policy discussions[40], and was an important drive behind SDPC and the implementation of respectful dialogue.

Barry and Neil's engagement in the narrative is used to show how engagement can take different forms, and that one form may not suit everyone. For example, Neil does not enjoy large groups, he prefers to engage under his own terms, and this should not prevent him from taking part. For him online access worked the best, and it is not unreasonable to conclude that many people would benefit from this kind of engagement. Similarly Barry was not in a position to be attending large stakeholder events, but he did attend his local recovery meeting groups. From my own experience these groups can be engaged in order to get feedback on how people who use drugs would like to access treatment: barriers to access, reasons for access etc. Rarely are these groups asked whether they agree in the criminal justice aspect of drugs, and even more rarely are they asked whether they feel their life has been harmed by the criminal justice drug interventions. This is something that needs to be developed if participation is to include a wide range of voices, as well as challenging the institutional stigma directed towards 'problem drug users'.

One of the most important points to pull from the Meta narrative is that the way forward in regards meaningfully engaging as wide a range of stakeholders in the policy process, is to create a safe space for everyone to be honest about their drug use, and views of drug use. This enables one to take into account the myriad reasons why people choose to use substances in the first place, and encourages dialogue on the assumptions and presumptions underlying drug policy deliberations.

Summary

This chapter explored the role that fictionalised narratives can have in exploring policy 'problems' by providing context and empathy towards the stakeholders in the policy communities. Critical race theory uses personised narratives to highlight the often brutal affect racism has on individuals and institutions, and so too in this way CDT can use narrative to expose the harm done by policy decisions, and humanise the different stakeholders affected.

Critical drug theory is a work in progress and will need to be developed and tested by myself and other scholars in order for it to become part of the critical theory landscape. However, critical drug studies exists as an academic area of study, and CDT could form part of this knowledge production. CDT is grounded in critical thought, with the underlying premise that the foundations of drug policy, national and international, are based on ideological reasoning that is

[40] Arguably there is not good facilitation in this narrative, however in my experience this expanding horizon was evident in well facilitated discussions.

often used to suppress and silence those who seek to challenge the status quo. Subjecting policies to critique and critical evaluation, such as research into the impact drug laws have on individuals and society (as opposed to the impact drug *use* has), should be advocated, along with public engagement on the complexity of drug use and harm.

The following, and final chapter brings CDT, my WPR analysis and my research questions together. It will set out how this thesis has answered the core research questions using the WPR Approach. It will also look at recent developments from my case studies to highlight how this project has provided avenues of participation for current stakeholders, and suggestions of participatory practices that could be implemented in the future, in order to create sustainable and meaningful stakeholder engagement in drug policy formation, both here in Scotland and abroad.

Chapter 10

Conclusion

The aim of this research was to explore the drug policy communities in Scotland to determine what the master and counter narratives were in regards to drug use and drug users, and whether it was possible to develop meta narratives that encompassed both, and provide a common way forward. Within this, the research explored the role that historical legacies had on the development of these narratives, and the impact these narratives have on meaningful engagement of stakeholders. In doing so, it uses critical race theory and Bacchi's WPR approach to explore what the 'problem' was represented to be, and how the 'problem' can be challenged.

I have been working on this thesis for over 6 years now, with periods of fulltime paid employment in-between. It has been difficult to maintain the momentum, and this last chapter is my sigh of relief! We are experiencing such upheavals in our lives: I am currently writing this after 10 weeks of lockdown in a house with two wee mental children, and a partner who is just as busy and stressed as I am. You will have your own challenges, even if the lockdown has been lifted by the time this is read. Life will never be the same, I hope.

It is in that vein of thought that I will not represent the entire thesis in a weighty conclusion. Instead, I structure into three parts: the first part sets out the thesis in a brief paragraph; the second addresses the core research questions with the findings from each chapter using the WPR Approach questions. The final section will reflect on my own journey through this thesis. Evidence is provided for my findings in the previous chapters therefore, sticking with the narrative flow I shall only use in text citations when I present something that has not been evidenced before.

Doing Drugs Policy: In Brief

This research has shown that the policy world of drugs in Scotland has been constructed in a way that generates a field of relationships focussed on working within a harm paradigm resulting from 'problem drug use'. As a result, those who do not fit the 'problem drug user' category are excluded or ignored, and in some cases deliberately locked out of the policy development process through silencing, or 'constitutional side- stepping'. Running throughout the research is the exploration of the relational aspect of policy formation: that 'access' to policy formation is based on the relationship the stakeholders have with the various 'gatekeepers', whether they be individuals or institutions. These relationships are built on shared narratives, and these narratives can at times diverge and lock those involved into certain responses because of the inability to see beyond their constructed narrative. However, as set out in chapter 2, these narratives define the

horizon of the individuals, and by presenting situations that allow individuals to expand their horizons, new responses, and narratives can be envisaged. By setting out the master, counter and Meta narratives, it is possible to see where the 'problem' originates, what the critique of the 'problem' is, and a projection of what alternatives are possible.

Summary of Research Findings

'What are the master and counter narratives within Scottish drug policy communities?'

This research focused on the historical development of drug policy in Scotland, and how this has influenced the different ways in which stakeholders are involved in policy development more recently. As a result of the different methods used during data collection master and counter narratives emerged. By using narrative to highlight the impact specific knowledge and histories have on policy formation, it was hypothesised that there were competing narratives within drug policy communities about drug policy reform, informed by the history of public health and criminal justice interventions on drug use in Scotland, originating in the HIV/AIDs crisis of the 1980s. This core research question was designed to explore this hypothesis, to see what the master narratives were around the meaning of drug use, drug users, participation and policy reform. A further aim was to explore whether there are shared narratives which could enable the different drug policy stakeholder communities to work towards an understanding of different concepts of drug related harm, and solutions stemming from this.

Master Narratives

What's the problem represented to be, what are the presuppositions and assumptions underlying that representation, and how has it come about? (WPR #1/2/3)

This was explored in Part Two – Historical Legacies – where it was found that the 'problem' in drug policy is represented as the impact that 'problematic drug use' has on the well-being of individuals and society.

This research showed that the development of the narrative surrounding 'problem drug use' began in the early 1980's. During the 1980's there was a fundamental shift in the way drugs were bought, sold and used. Previously drugs such as heroin were used by a small cohort of 'bohemian' users, however, in the early 1980's drug dealing started to become more commercial. It is argued that a part of the reason for this change was the social upheaval caused by Conservative policies at the time, which resulted de-industrialisation affecting many communities. As we saw this created a sense of hopelessness amongst young people in the housing schemes of Scotland, and an increase in the use of drugs such as heroin as a way of dealing with such hopelessness. This narrative, of Conservative policies of the 1980's resulting in 'problematic drug use' and increasing

drug deaths decades later, has become part of the master narrative governing Scottish responses to drug use, and helped to shape the harm paradigm that dominates drug policy today. As a result of the increase in heroin use, and the resulting HIV/AIDs epidemic that engulfed the late 1980's, drug users were seen as people who *suffer* and *cause* harm as a result of their drug use, and therefore strategies to address this harm were seen as the most effective way of addressing this. As drug policy developed over the intervening years, the focus tightened, and in 2001 policy explicitly focused on 'problematic drug users'. By 2008 the concept of recovery had become embedded in policy responses, with the 2008 Road to Recovery strategy enshrining this in drug policy development going forward.

The impact of this narrative of harm on policy development, specifically stakeholder involvement in policy development, resulted in a focus on stakeholders who had experienced harm. Therefore, as the research shows, participants who have had experience of 'problem drug use' or are currently experiencing 'problems' arising from drug use, are the preferred stakeholders in drug policy deliberation. Furthermore, as a result of this harm narrative, or harm paradigm, underlying assumptions around drug use are not challenged.

The research shows that the underlying assumptions built into development of drug policy deliberations are that: most drug use is harmful; that most individuals would like to stop using drugs; that people in general would live more fulfilling lives if they were not using drugs; and that drug use does not serve any medical, therapeutic, spiritual or pleasurable purpose outwith the formal settings of treatment. As a result, the tensions around drug policy reform tend to focus on two kinds of reform – public health based reform, which is within the full capacity of the Scottish Government, and legislative, or structural reform, which includes changes in legislation, but also changes in policy that shift the focus to decriminalisation of drug use. Changes in legislation are not within the competency of the Scottish Parliament, but changes in policing and prosecution policy are within the competence of the Scottish institutions responsible.

As seen, public health reform has been taking place over the last 10 years, and significantly increased over the data collection period. However, as this research shows, the reform embeds responses within a problematized harm narrative, or paradigm, resulting in the silencing of different narratives around drug use and drug policy reform.

Counter Narrative

What is left unproblematic in this representation, where are the silence, and what effects (discursive and lived) are produced by this representation? (WPR #4/5)

This research showed that as a result of the historical focus on injecting opiate use that increased the risk of HIV/BBV infections, all other forms of drug use have been ignored or silenced. During the 1990's, when Scotland witnessed an increase in psychostimulant drug use such as MDMA and amphetamine, the response from the UK Government was to pass legislation

to prevent these drug users from gathering and listening to music. Heavy enforcement and criminal sanctions were applied, and continue to be applied to this cohort of drug users. Throughout the thesis I have presented stories of those affected by this enforcement, and it was shown that the harm done to individuals as a result of the criminal justice framework can be the same, if not more harmful than the drugs themselves.

What this research has shown is that drug use for pleasure or recreation is not a focus of the Scottish Government, and policy deliberations are not concerned or interested in the views of those who use drugs for these reasons. The issue with this is that many people go through periods of drug use that may be considered 'problematic', but often come out of it on their own. The idea that there is a class of drug users that are always 'problematic', and a class of users that are always 'recreational', is a myth. The othering of 'recreational' or 'non-problematic' drug users as separate from 'problem drug users' has resulted in alienation of most drug users from the institutional structures. This is compounded by the criminal justice framework that applies sanctions for actions that would not be considered harmful to self or others if the drug being taken was legal, preventing otherwise law abiding citizens from being open about their drug use, and therefore preventing meaningful engagement in drug policy deliberations.

What are the challenges in engaging different epistemic communities in a participatory policy process?

Master Narrative

What's the problem represented to be, what are the presuppositions and assumptions underlying that representation, and how has it come about? (WPR #1/2/3)

This research has shown that the master narrative on stakeholder engagement is of consulting with people who have lived or living experience of 'problematic substance use'. At the time of data collection the level of engagement was at the consultative level – through surveys and creation of the specific LLEEG to feed into the horizontal dimension of policy development. However, as the research has shown, engagement was limited to this group, and even this group had a marginal role in policy development, despite the commitments to increasing their presence. As the research shows the LLEEG group were part of the Partnership for Action on Drugs advisory structure to the Scottish Government, but they were never involved at the agenda setting stage. Since the data collection period PADS have been disbanded and a new Drug Deaths Taskforce has been set up, with 5 out of the 23 people having explicit lived experience. I have heard through private communication that the input from the lived experience groups is limited, and the level of frustration still exists. Indeed, a recent comment from someone who works closely with the lived and living experience group, and the Scottish Government summed it up: "*Getting involved with "Gov stuff has a tendency to suck the life out of anyone. So much effort just to feed the inertia*" (private communication).

Counter Narrative

What is left unproblematic in this representation, where are the silence, and what effects (discursive and lived) are produced by this representation? (WPR #4/5)

A further research question was on the participatory aspect of the research. Initially this question was seeking to explore why stakeholders such as drug consumers were not being consulted or engaged in drug policy development. This changed due to the Scottish Government making a commitment to engage drug consumers (and a broader range of stakeholders) in drug policy deliberation. However, the question remained pertinent, with a focus on how meaningful that engagement is, thereby highlighting the challenges in participation.

The research has shown that the focus on harmful problem drug use has meant that other forms of drug use have been ignored, and at times actively silenced. People who use drugs but do not engage with treatment services, or do not use drugs to such an extent that they come to the attention of public services, are not the focus of policy. The focus on 'problem' drug use has resulted in a focus on certain kinds of drug consumption, and a policy strategy to match that - recovery. As a result, only certain stakeholder views are taken into consideration when participation is being designed at an institutional level, and only certain discourse is considered legitimate. As this thesis proposes, these stakeholders can be separated into four typologies, or narratives: the professional, the sick, the recovered and the happy stakeholders.

The legitimacy of the stakeholder determines the level of ‘meaningful participation’: the amount of engagement and involvement in the policy process individuals are given depending on their perceived legitimacy. Importantly for this research it is aspects of the sick and happy drug user that appears to be afforded the least legitimacy, at least in the context on non-opiate based drugs (the sick opiate user is considered a legitimate stakeholder under the term ‘living experience’).

The way in which institutions, in particular the Scottish Government, avoid meaningful engagement with these stakeholders is through what I call ‘constitutional side-stepping’. As shown, criminal justice sanctions for drug use resides with the UK Government, therefore any legislative changes that would see *de jure* decriminalisation of drugs can only be enacted by the UK Government. Engagement of so called ‘non-problematic drug users’ in the policy process therefore is seen as non-essential, if it is considered at all. With the focus of drug policy being on the impact of ‘problem drug use’ on individuals and society and a public health response, those who are not considered to be presenting a public health ‘problem’, are not considered in the policy development at all. This is despite the fact that there are many harm reduction initiatives that would not require legislative changes at a UK level, such as drug checking in clubs and festivals, *de facto* decriminalisation or possession of drugs, and involvement of drug users at every level of the policy making process.

The silencing, or ignoring, of people who use drugs but are not part of the 'problem' drug paradigm is part of the 'gatekeeping' carried out by institutional officials, and prevents a wider range of stakeholders from taking part in the policy process. As shown in the thesis, access to institutional engagement is determined by the relationships between the gatekeepers and the stakeholders. As we saw, my relationship with the Scottish Government gatekeepers changed over the course of my involvement. When I presented as a professional representing academic involvement I was afforded immediate and swift engagement with policy makers. However, when I became involved in more contentious groups such as the MCRS, and as a result had to negotiate the different relationships involved, I was slowly locked out of the policy process.

The organising in and out of decision making is a common factor in policy making, as shown in chapter 7. As discussed, policy can be viewed as both horizontal and vertical (Colebatch, 2009). The vertical dimension is concerned with the authoritative aspects of policy making – the following of rules and authorized decision making. It shows that in policy decisions there is often a line of legitimate authority, with (in the case of drugs policy) a minister as the top decision maker, and the various subordinate civil servants authorised to enact the decisions. The horizontal dimension on the other hand, according to Colebatch (2009), views policy as "*the structuring of action*" (23). It shows that policy involves multiple actors, agencies and participants that do not have lines of authority, yet are part of the policy process. They bring different ideas of what policy is to them, and how these ideas and engagements are enacted from the basis of horizontal policy making (Colebatch, 2009, ch.3). As argued, it is better to think of policy making as a collection of people participating in policy through the different channels available, rather than one single set of policy makers as such (Ibid).

However, there is a third dimension, of those side-lined out of the policy making arena completely: most people who use drugs (Diagram 7). The stakeholders silently engage if they are part of the drug policy dimensions, or exist within the wider policy communities, but never have the opportunity to engage in policy development explicitly. Arguably their voices are heard through various media campaigns, and tacitly through the unspoken knowledge of many people working within drug policy, but at an agenda setting stage their voices are missing. As this research shows, the main reason for this is the constitutional argument, and legality. Admitting to a crime, especially one which has additional labels attached to it, would be career suicide for many, therefore only those who have already internalised the label of drug user will be willing to openly engage as one.

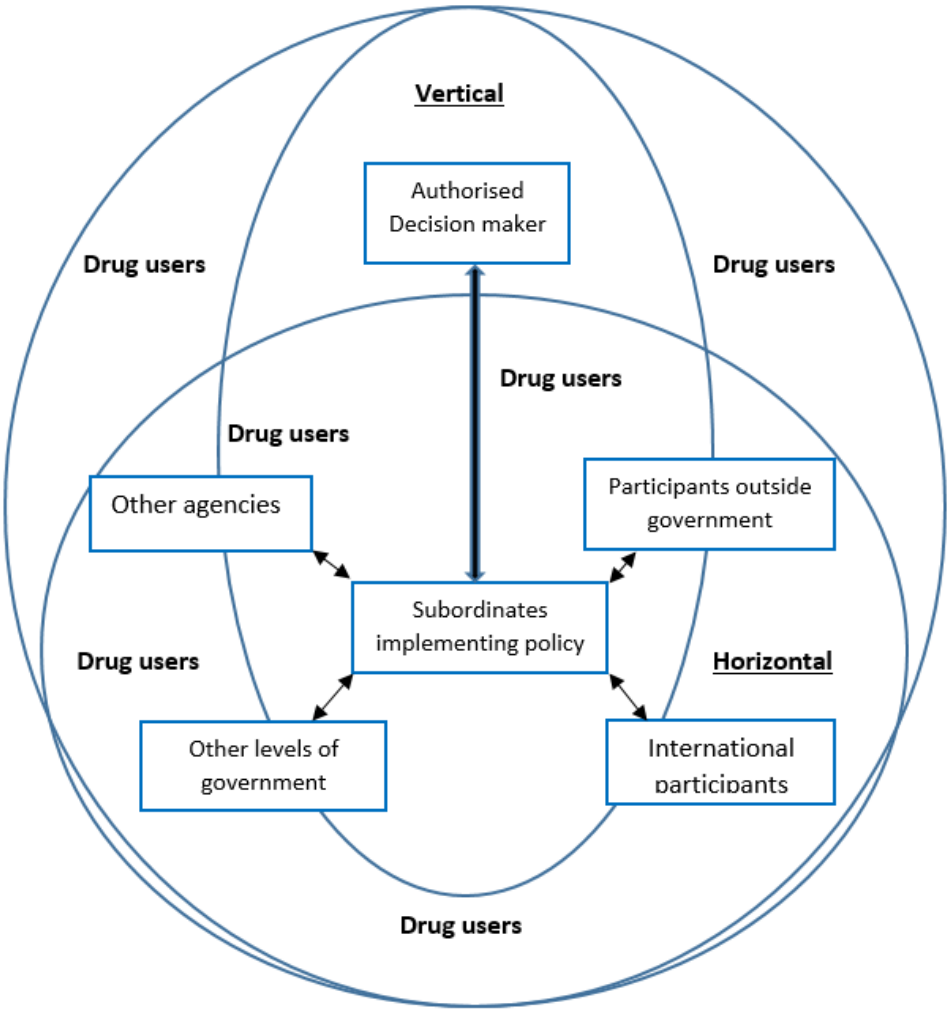


Diagram 7. The hidden stakeholders (Colebatch, 2002) additional design by Anna Ross

This aspect has been one of the most difficult ones for me. At the beginning of the research I was unsure whether I would 'come out' as a drug user, both during the data collection and in this thesis. I was warned by many that coming out about my drug use may risk my professional career, and by others that it may not be relevant to the research. However, as I began to develop the methodology, create SDPC and start the interviews, I realised I could not pretend that I was somehow 'other' to those who I was engaging with. I therefore decided to use my experience, of both 'problematic' and 'recreational/therapeutic' drug use as a way to develop both my professional and research persona. As has been discussed this resulted in me being involved as a lived and living experience representative and gave me access to certain policy environments that I would not have had otherwise, but it also at times blurred the lines between researcher with lived experience - therefore an advocate - and activist/lobbyist. Traversing these boundaries can be tricky, particularly when the issue is about drugs, an area already stigmatised with the label of inability to refrain from compulsive behaviour, or high sensations seekers (Palmgreen, 2001).

Being an advocate for drug consumers, and being open about one's own drug use, will result, in my experience, in any advocacy work being labelled as lobbying.

Furthermore, in regards the dimension of policy making, while the structure of policy deliberation may allow for multiple inputs and options for engagement, ultimately it is the civil servants who write the recommendations as policy briefs/reports/bills or sign off the cheques, and the minister in charge who rubber stamps it with the authority. It is therefore possible to have a well written policy document, with a range of expertise and recommendations, yet little in the way of meaningful engagement on the issues going forward. As the research has shown, *until the politicians have a level and degree of comfort then the change will not happen*" (anonymised participant, SDPC, 2016).

What is critical drug theory, and how can it help us understand drug policy formation in Scotland?

How can the representation be challenged? (WPR #6)

> *"Drugs policy is populated by people who have been involved in policy for many years and are either entrenched in their views of what drug use is and who the drugs user is – ie problematic users – or weary and saddened by the lack of going forward regarding policy"* (Senor Drug Advisor).

There is an entrenched sense of ennui amongst the drug policy community in Scotland, resulting from years, if not decades, of failed policies and promises. As I write this I feel some level of sympathy for those in charge of drug policy, because it is not the fault of any one individual per se (although as the research shows, relationships form a major aspect of policy development), but an institutional lack of drive to push for greater reform. This lack of drive was a recurring theme throughout the research, but the ultimate structure of the thesis means that this theme will need to be developed in another paper. However, throughout the research period I came across this frustration, weariness and sadness that ultimately drug policy will always be focused on 'problem drug use', and drug users will always be viewed as 'problems'. Within this weariness is a critique of the underlying foundations that responses to drug use rests upon – that all drug use causes harm. Time and again I came across practitioners who questioned this premise, yet did not have the ability to openly challenge it, because of the harm paradigm that drug policy is situated within. This, in part, is what spurred the development of critical drug theory (CDT).

The development of CDT is set out in chapter 8, where I showed how the inspiration came from critical race theory, and the tenets outlined by CRT scholars. It was argued that the narratives of drug harm and the medico/legal structures which surround problematic drug use means that evidence and participation are focused on a small section of the drug using population, namely

problematic drug users. Furthermore, government, legal and education institutions in particular, work within the drug harm paradigm carrying out the functions of oppression, by applying laws that disproportionately affect marginalised members of society. CDT has therefore been developed to provide a framework to legitimately critique the foundations that drug policy rests upon, and challenge the legitimacy of current policy responses. The question for this research was can this theoretical development help us understand drug policy development in Scotland, and specifically the barriers to wider participation, and the underlying narratives that exist within Scottish drug policy communities?

The research has shown that drug policy is developed within the narrative of drug harm (the harm paradigm). As a result discussions on what is considered harmful drug use, who decides what is harmful, what drugs are the most harmful, and who decides whether the harm was caused by drugs in the first place, are silenced or ignored. Drug use is the 'problem' picked from a range of 'problems' whenever a 'problematic' person is seen to be using drugs: drugs are presumed to be causing the harm instead of other factors such as mental health, PTSD, trauma, financial stress, the stress of living in this society etc.. Furthermore, drug use is used as a justification for certain behaviours as opposed to the epidemic of for example male violence, or poverty etc., and drug 'related' crime is often associated and linked to wider organised crime.

However, as has been shown, this focus on the harm paradigm prevents a large section of drug users from engaging with drug policy, and therefore creates a barrier to wider participation. The critique of the harm paradigm within drug policy is part of CDT. The four tenets of CDT – intersectionality, institutional power, social construction and narrative/counter narrative- allow for different perspectives to be taken into account, and this research focused on narrative as a way of giving voice to the silenced and marginalised by creating stories that highlight the impact of the policy, and develop common responses. In particular, using the CDT framework we can explore the role that pleasure and therapeutic use has on individuals, as well as the harm resulting from the current criminal justice and public health based responses.

A challenge for policy makers therefore is whether it is possible to move beyond the harm paradigm to accommodate different perspectives, and narratives, within the drug policy governance process. The aim is not to replace the current master narrative, because it is not a 'false' narrative, but to move to a place of plurality: where all voices are given a forum. As it currently stands official narratives systematically exclude narrative pluralism by only taking into account the narratives that fit the Scottish drug policy agenda. There are practical things that could be implemented, as discussed in the previous chapters, such as widening the possibility to participate, and engaging on drug policy issues through a human rights lens, as opposed to a public health lens. This is an area I plan to work on going forward, to develop coherent alternative narratives that may help policy makers understand how narrative and participation can improve the engagement of stakeholders, and ultimately of drug policy governance.

Another aspect of CDT which falls within the narrative tenet is the use of language to enact change. The research showed in chapter 7 that 'narrative interventions' can have the effect of creating meaningful dialogue between stakeholders, and challenge the institutionalised stigma that persists within drug policy. As we saw, the initial draft of the 2018 Scottish drug strategy was entitled 'Seek, Keep and Treat'. This was met with anger by the LLEEG who viewed it as stigmatising and not reflective of what they envisioned drug policy to look like. In response those responsible for the language changed the title to 'Rights, Respect and Recovery'. In doing so they demonstrated that there is the possibility of enacting change within the institutional settings, albeit limited to language, and addressing the harm done by using stigmatising language.

Finally, chapter 9 took all the of the stories and narratives from both my life, and the research, and set out the master, counter and meta narratives to demonstrate how one can develop fictionalised narratives that speak to a range of opinions, show an array of different stakeholders, and cultivate empathy in the reader towards people's different experiences. In doing so the research highlighted both the harm of 'problematic drug use' and the harm of drug policy responses, and made suggestions of how both harms can be mitigated. This is probably, in my opinion, the most important contribution of the research. Developing empathy towards our fellow citizens is paramount if we are committed to equitable policy, and drug policy is an area where empathy from those in control of the policy dimension is often lacking. It may be that because most external stakeholders (such as third sector, campaign groups, people who use drugs) are so vehemently empathic and emotional in their engagement with policy makers, that the response is quite guarded, or it may be that because drugs is viewed as a 'wicked issue' empathy is not considered appropriate. The criminal nature of drug use further alienates drug users' voices due to the deviant nature of their activity. Whatever the reason for the inertia and lack of explicit empathy, by using stories, both fictional and biographical, empathy can be developed and the impact of policy can be seen from a different angle. If nothing else, this research has shown how personal connection and storytelling can highlight alternative policy options that may reduce the harm done to all stakeholders in the process.

My Journey through the Thesis

Applying the WPR questions to my own 'problem' representation.

As discussed in chapter 3 there is a final seventh question which challenges the researcher to apply the WPR approach to their own problem representation (Bacchi & Goodwin, 2016):

> *"[B]ecause analysts, similar to other people, tend to be located within the "unexamined ways of thinking" that underpin policy proposals, it is difficult to "stand back" and critically scrutinize those problematizations. For this reason, the WPR approach includes*

> *an undertaking for policy workers/analysts to engage in self-problematization, seeking out possible forms of domination in their own proposals and problematizations"* (Bacchi & Goodwin, 2016, 40).

So, what is my 'problem' and how is it represented to me? I have been honest from the start about what motivated me to undertake this research, and have incorporated the academically developed concept of situated/background knowledge into the research design and writing. However, it is incumbent on me to analyse in a bit more depth the way in which I situated the 'problem', in order to see how my thinking may have dominated the way in which I collected and analysed the data.

When I started the process of developing this research I had in mind what the 'problem' was. I have never viewed drug use as a 'problem', and always viewed drug policy as the 'problem'. Although throughout my life I have seen friends, acquaintances, and clients suffer as a result of their drug use, I have always viewed their 'problematic drug use' as a symptom of something deeper. Drug use, to me, represents fun, excitement, mind altering, social gatherings, losing myself in music, relaxing, escaping and therapy. Because of this, when I have seen someone suffer at the same time as using drugs, I have seen the drugs as a way of coping, rather than the suffering stemming from the drug use. This is despite being in a relationship with someone dependent on heroin, who had no obvious childhood trauma or life trauma he seemed to be escaping from. Starting at an early age I have learnt to hide my drug use, and in doing so developed a deviant personality, distrustful of authority, especially the police, seeking out alternative groups, and being vocally anti-authoritarian. This part of personality reared its head in a surprising way during the lockdown of 2020. I found it extremely difficult to 'obey' the lockdown rules, because I am so used to ignoring rules that I do not think should apply. This is not to say I did not agree with the lockdown, but the little Hitler's and rule lovers anger me, and I found myself breaking the rules in little ways just to make sure I was not completely conforming! The point of this is that my representation of the 'problem' was the 'problem' of drug policy. I view drug policy as an oppressive framework that seeks to control behaviour that may threaten the dominant social order, and have had this view since the age of 15. My experience of police oppression and violence in the mid 90's as a young teenager marred my opinion of the drug laws, despite positive experiences later on. For example I had many interactions with police at after parties, most of which were friendly and never involved criminal prosecutions. But I have seen friends lose their lives to the criminal justice system, contaminated drugs, and lack of support. Therefore, I entered this research with a strong representation that drug policy, and its enforcement, was the 'problem', and those making the policy the creators of that 'problem'.

Reflecting back on my findings, 6 years after starting, I wonder whether I spent that time creating a thesis that merely supports my own 'problem' representation! Yet personally I have come a long way. To apply another of the WPR questions – how can this representation be

challenged or disrupted, I would say that meaningful engagement is what altered my personal 'problem' representation. When I entered the policy field I had strong views on all things to do with drugs. Through the interviews, but in particular through the dialogue created by SDPC I began to understand alternative viewpoints. I cultivated a more nuanced response to those who did not agree with me, and realised it is better to have respectful dialogue between those who may disagree with one another, because this opens the ground for deeper understanding of the concerns that many people have. A comment I received several times was along the lines of *'see Anna, you are one of us, but you're also one of them because you can speak their language.*" This comment invariably came when I highlighted some technocratic issue, how to word an email that would have better effect, or making sure meetings didn't clash with important political announcements etc.. It highlights to me one of the barriers to change in drug policy: that you need to appear a certain way in order to access certain policy arenas. But it also highlights that over the years I have worked to develop the ability to speak to many different 'publics', and represent the voices of the marginalised without losing my own sense of self.

-----The End -----

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Appendix 1: Lists and Reports

This is by no means a comprehensive list of publications relating to drugs in Scotland, however it lists all of the key policy documents and reports produced by organisations involved in policy advice at that time, and gives an overview of the direction of travel.

My research methods for these documents were as follows:

- For Scottish Executive/Scottish Government reports, including those from SACDM and the EIU, I used the Scottish Government publications search engine with the key word 'drug', together with each year from 2000 to 2016. I did not include evaluation reports (unless key to policy shifts) and other reports detailing specific bits of research. I this did to limit scope and to focus on key documents, as opposed to every piece or research conducted or commissioned by the Scottish Executive/Government. I also used my own knowledge of the documents, and references from Brian Kidds' thesis (Kidd, 2013).
- For reports and documents not produced by the Scottish Executive/Government I used several research methods. Firstly, I was lucky enough to be handed all of Susan Deacon's notes, including reports and publications, from her time at the RSA, where she was the lead Scottish researcher for their report '*Drugs – facing facts'* (2007). In addition, I received input from my co-convener of SDPC, Mike McCarron, who has been embedded in the Scottish drug policy landscape since the 1990s and has been a committee member of several important reports. He was able to direct me to the more obscure reports such as the Glasgow Citizens Jury on Drugs (2001) and Melting the Iceberg of Scotland's Drug and Alcohol Problem (2010). Finally, I used my own knowledge of the drug policy landscape and went directly to the publications of 3rd sector organisations involved in policy advice and collaboration.

Pre-Devolution

1994 - McLelland Committee Report
1994 - Scottish Affairs Committee, First Report. *Drug Abuse in Scotland.* Vol 1
1995 - Conservative Drug Strategy Document, *Tackling Drugs Together*
1998 - Cabinet Office, *Tackling Drugs to Build a Better Britain*

Post Devolution

1998 – Drug Courts were set up to specifically deal with drug cases, and **Drug Treatment and Testing Orders (DTTO's)** were implemented as a way of encouraging those caught with drugs to stop using them.

1999 - Scottish Executive, *Tackling drugs in Scotland: Action in Partnership*.

2000 – The Scottish Executive's Drug Action Plan. A complimentary report to the 1999 strategy which sets out how Drug Action Teams (DAT's) will support the strategy, and what the Executive will commit to do over the next 10 years.

2000 – The Scottish Crime and Drug Enforcement Agency is set up to tackle serious organised crime, including the trafficking, production and sale of illegal drugs. See further: http://www.gov.scot/Publications/2004/12/20345/47606

2000 – Inquiry into Drug Misuse and Deprived Communities by the Social Inclusion, Housing and Voluntary Sector Committee. Volumes 1 and 2

2000 – Drug Misuse Research in Scotland: the Contribution of Research to Scotland's Drug Misuse Strategy. A report commissioned by SACMD prepared to explore the research behind the Scottish drug strategy: Tackling drugs in Scotland.

2000 – Effective Interventions Unit set up.

2001 - Scottish Executive (2001) *Getting Our Priorities Right. Policy and practice guidelines for working with children and families affected by problem drug use*

2001 - Scottish Executive Central Research Unit (2001) Arrest referral: a guide to principles and
practice. Retrieved online at: *www.scotland.gov.uk/Publications/**2002**/05/14526/2751*

2001 - Glasgow Peoples Jury on Drug – the first example of the use of citizen jury's to explore drug policy in Scotland.

2001 – Report of a Working Group for Piloting a Drug Court in Glasgow. Working group set up the Justice Minister Iain Grey to evaluate Drug Courts.

2002 - SACDM: Psychostimulant Working Group Report. Highlighted the need for additional services aimed at psychostimulant drug users, hence the increase in funding from organisations such as Crew 2000

2002 - Effective Interventions Unit - *Drug Treatment Services for young people.* 'A report of the findings of a systematic review of published research of treatment and care services for drug using young people and a separate literature review of the current statutory framework.'

2002 – Effective Interventions Unit - Integrated Care for drug users: Principles and practice. 'This document provides the rationale for integrated care, its definitions and concepts and the key principles and elements of effective practice drawn from the research evidence.'

2002 - Effective Interventions Unit: The effectiveness of Treatment for Opiate dependent Drug Users: An International Systematic Review of the Evidence. Importantly this

highlighted the need for more psychosocial support, in addition to a focus on detoxification and abstinence based treatments.

2003 – Scottish Executive –*National Investigation into Drug Related Deaths in Scotland.* Substance Misuse Research.

2003 – Scottish Executive - G*ood Practice Guidance for working with Children and Families affected by Substance Misuse: Getting our Prioritise Right.*

2003 -SACDM - *Mind the Gaps. Meeting the needs of people with co-occurring substance misuse and mental health problems.* Edinburgh: Scottish Executive.

2003 - Scottish Executive's Annual Report on Drug Misuse. Findings from 2002 on how the Drug Strategy is progressing. Well according to this report.

2003 – Crime and Criminal Justice Research Programme - *Establishing Drug Courts in Scotland: Early Experiences of the Pilot Drug Courts in Glasgow and Fife - Research Findings*. Commissioned by the Scottish Executive to evaluate drug courts.

2003 – Scotland's Drug Problem – Report of the Conference organised by the Royal Society of Edinburgh.

2004 – Scottish Executive - *Supporting Safer, Stronger Communities : Scotland's Criminal Justice Plan. Chapter 2: Tackling Drugs in Our Community.* Puts in a range of measure aimed at problem drug users including treatment and community measures.

2004 – The Effective Interventions Unit. *Advocacy for Drug Users: A Guide.* The Scottish Executive.

2004 - Effective Interventions Unit: *Reducing the impact of local drug markets: A research review.* The Scottish Executive.

2004 - Effective Interventions Unit: *Examining the injecting practices of injecting drug users in Scotland.* This is a summary of a report of research into the injecting practices of injecting drug users in Glasgow which paved the way for investigations into harm reduction initiatives such as drug consumption rooms.

2004 – Drug Outcome Research in Scotland (DORIS). This research conducted by Neil McKegeny and others re-ignited the debate around abstinence versus harm reduction as a result of finding which appeared to show that rehabilitation and methadone treatment were not effective at achieving a drug free life. The repercussions of this study were felt for many years, indeed the term 'parked on methadone' is still commonly used today. This is explored more in Governance.

2005 - SACDM *Working Groups on Drug Related Deaths* – The Scottish Executive

2005 – Scottish Executive - *Taking Action to Reduce Scotland's Drug Related Deaths: The Scottish Executive Response to the Scottish Advisory Committee on Drug Misuse Drug-related Deaths Working Group, Report and Recommendations*

2005 – The Scottish Executive: Substance Misuse Research - *National Investigation into Drug Related Deaths in Scotland, 2003*.

2005 - Effective Interventions Unit. *Integrated Care Pathways Guide 9: Single Shared Assessment for Drug Users.* To assist practitioners, managers and commissioners in reviewing the way that they design, record and deliver screening and assessment services to people with drug problems.

2006 - Scottish Executive - *Mental Health in Scotland. Closing the Gaps – making a difference.* Edinburgh: Scottish Executive

2006 - saw numerous small evaluation projects on topics such as Know the Score campaigns, Lloyds TSB funded project Partnership Drugs Initiative, findings from the Crime and Justice Survey, and Drug Courts evaluations. None of these however were key policy publications and are therefore not listed here.

2007 – Drugs and Poverty: A literature review. *A report produced by the Scottish Drugs Forum on behalf of the Scottish Association of Alcohol and Drug Action Teams.*

2007 - SACDM Methadone Project Group. *Reducing Harm and Promoting Recovery: a report on methadone treatment for substance misuse in Scotland.* Edinburgh: Scottish Government.

2008 – SACDM - *Essential Care: a report on the approach required to maximise opportunity for recovery from problem substance use in Scotland.* Edinburgh: Scottish Government.

2008 – The Scottish Government - *The Road to Recovery: a New Approach to Tackling Scotland's drug Problem.*

2008 - Scotland's Futures Forum *Approaches to Alcohol & Drugs in Scotland, A Systems Mapping Approach to How Scotland Can Reduce the Damage to its Population by Alcohol and Drugs by Half by 2025.* Available at: http://www.scotlandfutureforum.org/assets/files/report.pdf

2009 – **The Scottish Government -** *Changing Scotland's Relationship with Alcohol: A Framework for Action.*

2010 – The Scottish Government – Best et al (2010) *What is the Recovery Evidence Base?* Available at: http://www.scotland.gov.uk/Publications/2010/08/18112230/6

2010 - The Scottish Government – Best et al. (2010) Research for Recovery: A Review of the Drugs Evidence Base. Available at:

2011 – Scottish Government - *Social Work Services and Recovery from Substance Misuse.* Available at*:* http://www.scotland.gov.uk/Publications/2011/03/18085806/0

2012 - Scottish Government - *Scottish Drugs Strategy Delivery Commission, First Year Report and Recommendations to Minister.* Available at http://www.scotland.gov.uk/Resource/Doc/360000/0121682.pdf

2014 - NHS Health Scotland – *Outcomes Framework for Problem Drug Use*. Available at: http://www.healthscotland.com/documents/24442.aspx Accessed 28/06/2020.

2015 – The Scottish Government – *New Psychoactive Substances Expert Review.* Available at: https://www2.gov.scot/Topics/Justice/policies/drugs-alcohol/NPSExpertReviewGroup accessed 28/06/2020.

2015 – The Scottish Government – *National Framework for Problem Drug Use.* Available at: https://www.gov.scot/publications/scottish-national-research-framework-problem-drug-use-recovery/ accessed 28/06/2020.

2016 – The Scottish Government – *Attitudes towards Dependent Drug Users.* Available at: https://www.gov.scot/publications/public-attitudes-towards-people-drug-dependence-people-recovery-research-findings/ accessed 28/06/2020.

2017 – NHS Health Scotland - *Drug Related Deaths Rapid Evidence Review*. Available at: http://www.healthscotland.scot/media/1609/drugs-related-deaths-rapid-evidence-review.pdf accessed 28/06/2020.

Appendix 2: Summary of SDPC sessions

Below is a brief summary of SDPC themes and discussion, up until the present, 2020. The final SDPC session is not part of the data collected, however it is included to demonstrate the sustainability of such a process, and is of interest to the research. More in depth reports on each event up until 2018 are available at www.sdpc.org.uk/documents/.

SDPC 1
Inaugural meeting to prepare the ground and build rapport between participants. 19 people attended
This session was led by John Sturrock focused on getting to know each other and what we felt the key issues in drugs policy. Overarching themes were: the heterogeneity of drug use and how policy and practice did not reflect this; lack of understanding of the law, how it is implemented, the impact it has on drug users and recovery, how it is interpreted, who has the power to interpret/change; systemic change and what are the barriers to reform, positive change and discussion. The top 3 key issues that came from the small discussion groups were: 1. Taking stock of the MDA '71 –negative and positive impacts and whether it is fit for a 21st century Scotland, including the socioeconomic cost of the current policy and practice. 2. Examining existing regulatory frameworks 3. Combination of several key issues- improving collaboration and communication between sectors and communities in order to clarify and better understand the impact of drug harm, and drug reform.

SDPC 2
Developing a shared understanding of the purpose and focus of SDPC and topics for further enquiry
"Following the successful first session, It was agreed that we should spend the next 3-4 months deliberating the various questions with a view to producing a document which would highlight the findings. What the actual outcome of this process will be is something we shall discover as we go through it. As John said, if we focus on the process the outcome will take care of itself. That being said I think it is fair to say many in the room want to be involved in something that will actually make a difference, and we can work through these discussions with this in our mind." From the record of discussion. As you will see below the format was not followed, but we found a good way to develop the conversations.

SDPC 3
This session had a presentation from Police Scotland on its changes to personal possession of cannabis, and a group exercise on problems and issues of Scottish drug policy
The presentation from Police Scotland provided an opportunity for SDPC to participate in giving feedback on proposed reform. In general it was felt that this is a valid a good use of SDPC time and more collaboration on similar proposals would be welcomed. The group exercise asked participants to individually identify 3 problems and/or issues surrounding Scottish drug policy, and these were stuck onto a wall and put into themes by the group as a whole. They highlighted 3 overarching themes: 1. Criminal justice and policing – including issues around criminalization, stigma, lack of clear implementation, harms associated with the system and policing. 2. Health and society – including issues around stigma and language used towards drug users, too much focus on addiction, not reflective of the various ways people take drugs, too focused on harm (no acknowledgment of benefit or how harm could be reduced within a regulatory framework) and over-emphasis on problem drug use. 3. Research, Evidence and policy – lack of evidence and money for research, no acknowledgment of public awareness of drugs, and need more policy put into practice. A final thought exercise highlighted that many in the room were keen for change, were appreciative of the space the SDPC provided for non-confrontational communication, and hoped that SDPC could continue to provide a space where reform and change were discussed, but also provide a place where they could speak freely. It was agreed that next session would be a blue sky exercise on Scottish drug policy.

SDPC 4
Presentations on rights, morality and health
Although the intention was that this session would be a blue skies exercise on what a Scottish drug policy could look like, we (Mike, Anna and Richard) structured this session around 3 themes that dominated the undercurrent of all discussions so far: rights (law), morality and Health. Although the session was structured to produce an agenda for change, the presentations and discussions they generated took up the full 2 hours. However, the discussions that took place were refreshing and most participants enjoyed the format of 3 short presentations followed by a chaired group discussion.

Because of this, future SDPC's conversations started to stray from the original structure and format that had been agreed during the initial process.

SDPC 5

Presentation by Beverly Francis of the Substance Misuse Unit

Beverly Francis of the Scottish Governments Substance Misuse asked if she could present an overview of the new policy advisory landscape.

Beverley gave us a general overview of how the new landscape is structured and where SDPC could fit in. Discussion highlighted that SDPC could provided an independent advisory arm, not constrained by the government agenda.

Beverley stressed that public engagement was key to any reform and that this is an area that needed to be looked at. Another area that the Government are keen to get more research and advice on is how to reduce stigma. Several people highlighted the role of the criminal justice system in producing and maintaining stigma, however this is not an area that Government can look at until there is obvious widespread public support.

SDPC 6 & Governance Workshop

UKDPC workshop on Governance with Roger Howard of the UKDPC during the afternoon.

In the late afternoon/early evening the session was on the the 'Regulation of Minor Offences'.

SDPC held a daytime workshop with Richard Howard where we looked at the governance of drug policy. The content of this workshop is not set out in this document.

In the later session we had feedback form Police Scotland and 2 other participants on the regulation of minor offenses.

1. **Athol Aitken** of Police Scotland gave feedback on the change to minor offenses that resulted in small amounts of cannabis being treated as minor offenses, as opposed to be charged as possession. The decision had been taken by the Lord Advocate and the police not to extend this policy to all class B and C drugs, largely on the basis that implementation would have been difficult and costly.
2. **Vicki Craik** of Crew 2000 gave feedback from small user group discussion she had had, however her feedback was based on the initial remit which was to gauge opinion on the pros and cons of extending minor offenses to all class B and C drugs.

3. **Iain McPhee** gave feedback on this issue highlighting aspects that he had come across in his academic research, in particular his knowledge of how such offenses are policed from a consumer perspective.

SDPC 7

Engaging the Public – 3 speakers and group discussion

Following the successful format in session 4 this conversation focused on public (stakeholder and wider public) engagement on drug policy initiatives. Oliver Escobar from the University of Edinburgh, and a specialist in deliberative forms of engagement, was invited to be our keynote listener, and gave feedback and ideas of ways forward.

Our three speakers were:

1. Saket Pryadashi –discussed the process of engaging the local and wider community regarding drugs consumption rooms in Glasgow. Three lessons were taken away from this and the resulting group discussion:
   i. People are not as averse to these initiatives as is commonly thought, and the media are not as adversarial as one might expect, in Scotland at least.
   ii. Proper engagement with the local community and businesses at an early stage is very important for providing evidence of local support. Furthermore, it is not always necessary to engage the public at large, as those who are affected are the ones who count when decisions about whether to proceed are made.
   iii. The formal process of getting such an initiative agreed involves multiple layers of bureaucracy. This can result in longer timescale, and in some instances the decision makers not having the time, or sufficient evidence, to make the right (in our opinion) decision. Good channels of communication are therefore essential, but not always available.
2. Stephen Malloy – discussed his involvement with the European Forum for People who use Drugs, and the initial stages of setting up a Scottish branch.
3. Mike McCarron – discussed his involvement with the Centre for Human Ecology and an event he had put on there.

Oliver gave his feedback, which highlighted the role that deliberative methods of engagement could have in this area. Group discussion focused on how to raise finances for such an initiative, and agreement that this was an important aspect of SDPC.

SDPC 8

Engaging the media – 3 speakers and group discussion

Andrew Learmonth of the National spoke to the group via Skype and gave us some insights into who to engage with the media. The main point highlighted from this evening was that the media will only get involved if they think there is a story to it.

Overall the evening was a success but there was a feeling that we had come to the end of this style of conversations, and that 2017 should open the possibility of more active engagement on issues.

SDPC 9

Taking Stock and Moving Forward

This session was chaired by Richard Freeman and John Sturrock facilitated, and helped us collate the various ideas we had on moving forward. 21 people attended, which is one of the best attended session yet. It was great to see many new faces and this made us realise that SDPC has now entered a new era and will change to reflect this.

Overall everyone who came felt positively about the last 9 sessions, although there was frustration expressed at how long it took to create consensus and whether this was really needed. However, once we had done our group work the last 30 minutes were dedicated to setting an agenda for 2017.

SDPC 10

Who are we, what are we?

This session took place in Glasgow at the Center for Contemporary Arts. It was attended by 20 people and took place during the afternoon, as opposed to the evening.

We spent a good amount of time discussing the vision statement and profile of the group. This was done in 4 groups of 5, and then a large group discussion. This process highlighted the challenges in getting consensus from such a variety of voices and ideas. the final vision statement is to be agreed by the group via email by the end of May.

The second half was a mapping exercise. Participants were asked to come up with 3 critical questions for Scottish drug policy, taking into account the overarching issues identified in conversation 3. The aim of this is to condense the questions into 5-10 critical questions which can be used as a toolbox for participants and their affiliated organizations to take to the wider community.

SDPC 11

Cannabis in Scotland

SDPC 11 was a joint event held by SDPC and Contemporary Drug and Alcohol Studies (CDAS) at the University of the West of Scotland which focussed on the regulation of cannabis in Scotland. It was held at the UWS room in Film City Glasgow and was attended

by 18 participants of SDPC.

The event was structured into 2 sessions. The first session was a presentation by Steve Rolles of Transform Drug Policy Foundation (www.tdpf.org.uk) on current international movements for the regulation of cannabis, and important policy aims and points to consider when designing a cannabis policy (slides attached to the email).

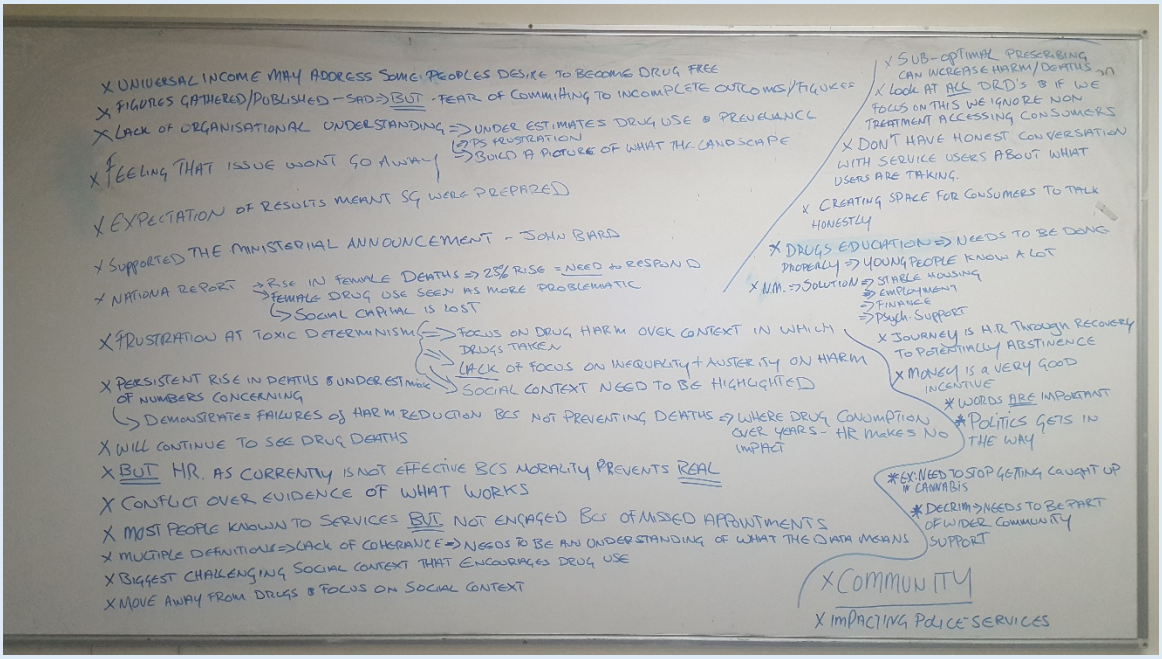
The second session was a presentation by Bernadette McCreadie on her experience of interacting with MSPs, and Anna Ross on the potential hurdles and challenges to reform.

Main Outcomes

1. **The regulation of cannabis is a policy option gaining traction internationally** and Scotland should be prepared to engage with the different models and processes involved.
2. **Creating a new narrative** on cannabis in Scotland, including challenging the idea that we are unable to do it because of the Misuse of Drugs Act 1971. There is flexibility and grey legal areas that can be worked through if there is a willingness by all those involved to engage with it.
    a. The new narrative must engage different publics in order to raise awareness around the impact of the current system of non-regulation on cannabis consumers, and potential outcomes of legal regulation.
    b. This may also include analysis on potential revenues such as Hemp production, cannabis research in Scottish universities and pharmacies, as well as taxable income from different regulatory models.
    c. It must also include the impact of criminal sanctions on consumers (physical, psychological and financial), and the financial impact on the Scottish Courts and police (see below on policy aims).
    d. Engaging with medical community in regards health benefits such as chronic pain, MS, arthritis and other neurological and nervous systems disorders which have shown to benefit from cannabis use.
3. **The Expert Working Group on Cannabis in Scotland** will take the outcomes of this meeting and work on a proposal for implementation. This proposal will be brought back to the SDPC group as a provisional draft and we will deliberate its content and how to take it forward. This will likely happen towards the end of 2017.
4. **A joint letter asking for drug policy reform**, akin to the joint letter handed to parties at the General Election 2017 will be drafted by **Steve O'Rawe** and circulated for signatures.

SDPC 12

Drug Related Deaths



Main Outcomes

There was broad agreement on the following outcomes:

1. **PUBLIC ENQUIRY -** Call for a public enquiry, commission or citizens assembly into drug policy in Scotland involving all stakeholders and requiring mandatory participation from identified stakeholders. This reflects Recommendation 66 of the Commission for Parliamentary Reform report (2017, p.69) which advocates the use of deliberative processes. SDPC will work towards this in the coming months. It was also felt that in order to input into the current refresh SDPC should work with the Scottish Government to collect submissions from stakeholders currently not engaging in the process.

2. **UNIVERSAL INCOME –** There was across the board support for the implementation of the Universal Income. It is envisaged that the impact of the Universal Income would help reduce the financial instability experienced by many problematic drug consumers that results from benefit sanctions for missed appointments, inability to access the right benefit advise, etc. Furthermore, the Universal Income would help reduce the stigma and stress associated with being in receipt of benefits, allowing individuals to access employment and voluntary opportunities not currently available. Finally, it shifts the focus away from economic need to social need.

3. **HARM REDUCTION -** Implementation of effective harm reduction, including **harm reduction champions** similar to recovery champions. It is felt that currently Scottish harm

reduction initiatives are not adequate. While there are embedded practices such as needle exchange and naloxone provision, harm reduction as a policy is not implemented across the board. Sub-optimal prescribing, the barriers currently being experienced in regards drug consumption rooms, low uptake of heroin assisted treatment, resistance to drug testing and decriminalisation of drug possession are all examples of inadequate harm reduction measures.

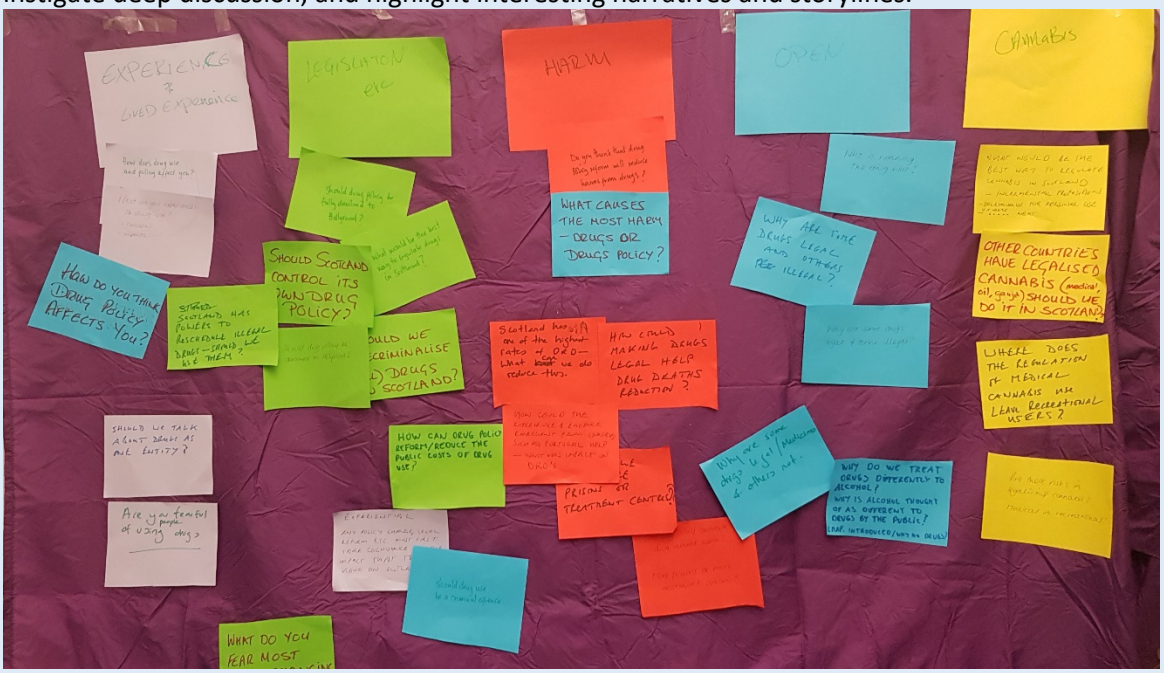
SDPC 13

Creating Collaboration – designing the engagement toolkit

This session was separated into two parts.

The first part introduced new members to the group, and set the boundaries and outlined the direction SDPC has been taking. This encouraged an open discussion on drug policy including a focus on trauma informed policy, and trauma resulting from policy.

The second section was an engagement activity to develop questions for an engagement toolkit. We were seeking questions that would require participants to explore their own thoughts and beliefs, which could then prompt wider discussion and knowledge exchange. The outcome of this exercise was the development of 5 main questions with sub questions which we all agreed would instigate deep discussion, and highlight interesting narratives and storylines.



1. Experiential questions
    a. What is your experience of drug use and drug policy?
    b. What impact does drug use and drug policy have on you?
2. Harm and Benefits
    a. Are there harms caused by drug use?
    b. Are there harms caused by drug policy
    c. Are there good aspects to drug use?
    d. Are there good aspects to drug policy?

3. Legality and open questions for prompting
    a. Why are some drugs legal and others illegal?
    b. What is the difference between alcohol and illegal drugs?
4. Scottish powers
    a. Should Scotland have control of drugs policy?
    b. If so how would we do it differently?
    c. What should we do about cannabis?

SDPC 14

Drug Consumption Rooms

This event took place in Glasgow and the discussion centered around the proposal that DCRs are an important bridge to moving from a prohibition perspective to a regulation model. The hypothesis is that DCRs contain practices that are the ones that underpin a regulation approach.

Therefore it would be a good piece of work to clarify what are key principles involved in DCRs and how they would apply in a national policy Scotland-wide. Such principles appear to be:

- Allowing DCR clients to carry and use drugs is effectively decriminalizing possession
- Recognition that many people will spend many years and sometimes a lifetime using drugs problematically pending good-enough resolution of adverse childhood experiences and other life traumas
- Heroin assisted treatment (HAT) for DCR clients and associated research raise questions about wider availability for problematic drug use but also the pros and cons of access by people with controlled or unobtrusive use of heroin
- The importance of DCR drug users building relationships with professionals and leading to treatment and other forms of help being taken up pose questions for every community drug service and their culture, especially intended and unintended stigmatization.
- DCR clients will no doubt be mainly older heroin users. The experience of working with them in DCRs will have many implications for working with older opiate users generally. For example, HAT?
- DCRs' non-threatening and completely accepting environment allows clients to be more honest about what's going on in their lives, more ready to open up, increases motivation to change, helps identify the best sequence of steps to change, encourages developing a wide range of help for flexible response to individual circumstances. Is this the reality of treatment and help across Scotland or are they limited in various ways – if so, how specifically?

SDPC 15

Memorial for Kenny Simpson
Pragmatic Approaches to Policing Drugs – which the changed to Pragmatic Approaches to Policing People who use Drugs during Covid 19

Initially we had organised this as a half day event, with speakers and in-depth discussion on policing drugs. However lockdown prevented this, and instead it took place over the internet. It was well attended all things considered, and we were still able to separate into small groups using the online 'break out' facility.

We had 3 speakers:

David Strang - former Chief Constable of Dumfries and Galloway, and Lothian and Borders, and latterly Chief Inspector of Prisons. David has ostensibly retired now, but is involved with a range of organisations, including being chair of the Scottish Association for the Study of Offending. David discussed community justice responses to PWD.
Angus Bancroft - Senior Lecturer in Sociology at the University of Edinburgh. Angus discussed drug use and the darknet, and the implication during the current lockdown.
Kira Weir - Training and Communications Officer at Crew 2000. Crew recently conducted a survey to understand how drug use, buying etc. has changed during the outbreak. Kira presented her findings of the survey so far, which showed that some drug use had increased and some people were finding it difficult to get hold of certain drugs. Well-being and reasons for using drugs were also surveyed.

The following discussion in small groups really shone a light on the need for more discussion on the legislation surrounding drug use, and the concepts of what a drug user actually is. An interesting input from the police was the fact that the majority of their time is spent with 'problem drug users' therefore it is difficult for them to discuss drug use without thinking about that cohort.

We will be holding further SDPC sessions in 2020. Our forthcoming sessions will be exploring how we would regulate should Scotland get devolved drug powers. Would we replicate the Misuse of Drugs Act verbatim, or develop legislation based on levels of harm both of the drug and by/to the individual), as suggested by the RSA 2007 report. Ultimately it is hoped that SDPC can continue to provide an independent and inclusive space for policy stakeholders to deliberate how Scotland can develop a drug policy based on human rights and public health concerns, and provide a strong narrative of change in the years to come.

Appendix 3: Respectful Dialogue

SDPC's Commitment to Respectful Dialogue

With thanks to collaborative Scotland www.collaborativescotland.org.uk

The Scottish Drugs Policy Conversation (SDPC) is a space for people with varied viewpoints and different experiences of drugs and drugs policy who wish to learn from this diversity, an
d influence future developments within Scotland.
SDPC welcomes respectful dialogue and open-minded reflection on options for improving Scottish drugs policy by engaging with stakeholders and the wider public.
In order to do this we, the participants, agree to:

- **Show respect and courtesy** towards all those who are engaged in these discussions, whatever views they hold;
- Acknowledge that there are **many differing, deeply held and valid points of view**;
- **Use language carefully** and avoid personal or other remarks which might cause unnecessary offence;
- **Listen carefully** to all points of view and seek fully to understand what concerns and motivates those with differing views from our own;
- **Ask questions** for clarification and when we may not understand what others are saying or proposing;
- Express our own views **clearly and honestly with transparency** about our motives and our interests;
- Respond to questions asked of us with clarity and openness and, whenever we can, with **credible information;**
- **Look for common ground and shared interests at all times**.

Appendix 4: The Right to Choose

"THE RIGHT TO CHOOSE"

MEDICINAL CANNABIS PROGRAM

SCOTLAND

Every single person in Scotland is unique and individual, especially when it comes to our health. The Right to Choose Medicinal Cannabis Program Scotland will ensure we are all treated as such and allow us to play a major role in deciding for ourselves how we want our healthcare to proceed. Right now, we are put onto a conveyor belt and treated with the same protocol as everyone else with the same named condition, which usually involves doing what your told and taking the drugs your prescribed. This must stop and patient involvement/participation/choice must be implemented. Thanks to technology people are far more educated on their own health issues than ever before and are realising there are more ways other than the pharmaceutical protocol. We demand THE RIGHT TO CHOOSE what we put into our bodies, this should be no one else's decision but each single individual person's right to decide for themselves.

HEALTHCARE PROFESSIONALS

Consultants/Doctors/Nurses/Healthcare Professionals must all be fully and properly educated on the therapeutic/medical benefits of cannabis. They must be properly educated on the differences between synthetic/medical cannabinoids and natural/organic/herbal cannabis. This won't be a difficult thing to do as there has already been so much research already done in other countries that are so far advanced to us. All this information is readily available online for anyone to read. Scotland must now take the lead on this and start considering collaborations/information sharing projects between our Universities and research facilities, and the Universities and research facilities around the world that already have a head start. There's no point reinventing the wheel. Consultants/Doctor/ Nurses must be given the autonomy to personally research/discuss/recommend/prescribe Cannabinoids for medical/therapeutic purposes to patients who choose this form of treatment.

THE PATIENT

When a person becomes unwell and visits their GP, the GP must give their patient the choice to be medicated with either traditional pharmaceutical medication, pharmaceutical grade cannabis/cannabinoids or natural herbal cannabis. The patient must then get to decide the supplier of their medicine or be given the choice to grow their own cannabis for their own needs. This must include the following:

1. A maximum allowance of 6 flowering cannabis plants at a time
2. A maximum allowance of 6 vegetative cannabis plants at a time
3. A maximum allowance of 18 seedlings/cuttings at a time (1,2,3 allow and ensure a constant rotation of cannabis growth and supply for more serious health issues)
4. The freedom to makes oils/edibles/concentrates as a responsible adult (we are more likely to die crossing the road yet we don't see anyone getting banned from doing that)
5. No THC maximum
6. No CBD minimum
7. Access to non-profit/compassion clubs where a patient can safely have up to 7 grams of clean and tested herbal cannabis or 1 gram of cannabis oil plus 3.5 grams of herbal cannabis or 1 gram of concentrate plus 3.5 grams of herbal cannabis, per day available on prescription. All non-profit compassion clubs must also register and adhere with SICA (see below).
8. Access to education from already experienced cannabis users on how to medicate with cannabis in said non-profit/compassion clubs.

9. A grant system for everyone who chooses to grow their own plants, to help cover the cost of equipment and expenses of this exercise, something that will save the NHS millions every year.
10. Issued with medicinal cannabis card to allow uninterrupted access to all the above.
11. The guarantee that any person who requires the help of a carer/assistant/family member with daily life tasks will not be putting their help at risk of prosecution. Carers/assistants/family members must have the same leniency afforded to them, they are only doing their job or helping a loved one so should also be free from prosecution.

POLICING

Police Scotland must be given the autonomy not to arrest or prosecute any person found in compliance with this program. Police Scotland must be given the proper powers and support from all Government departments involved in relation to this.

Policing of cannabis falls under the Misuse of Drugs Act 1971. **Schedule 4 of the Misuse of Drugs Act 197**1 specifies that the following acts involving a Class B drugs (cannabis) will result in 6-12 months imprisonment and/**or a £400 fine**

1. Cultivation of a cannabis plant
2. Production or being concerned in the production of a controlled drugs
3. Supplying, offering to supply, or being concerned in the doing of either
4. Having possession with intent to supply
5. Being the occupier, or concerned in the management, of premises and permitting or suffering certain activities to take place there.

Given that under the '71 Act possession of cannabis carries a 3 month prison sentence and/or a £2,500 fine, yet in Scotland consumers are given a Written Police Warning, and other parts of the UK have various ways in which they police possession, the terms of The Act are flexible.

It is possible that acts set out in 1-5 could be subject to a policy created in collaboration between Police Scotland, the Scottish Government and the Crown Office aimed at improving/protecting public health and reducing drug related harm.

A policy which allowed consumers to grow up to a 6 (flexible) plants, join social clubs where cannabis can be collective grown and potentially consumed (as in Spain, the Netherlands and Belgium), and provide a framework in which the £400 'fine' is applied on a regular basis which is strictly regulated potentially would not violate The Act.

Police Scotland officers and senior members must be fully retrained on how to deal with people in these special circumstances and what to do if they come across a particularly vulnerable person. This is not trying to increase the work load of our already over stretched and underfunded police service but the opposite. A program like this will free up a lot of police time to concentrate on far more serious crime.

INDUSTRY

Scotland must introduce cannabis/hemp to the market in a progressive manner by not allowing the monopoly for a multi-billion-pound industry to be handed over to the pharmaceutical companies alone. This is an industry that is big enough for everyone to be involved in so there is enough to go around. Scotland must make it possible for smaller businesses to access this market financially by creating a non-medical licensing process. Particularly to give farmers and small businesses the opportunity to grow/trade in cannabis/hemp, the same opportunity as multibillion multinational companies who can afford it get. Companies supplying natural herbal food supplements/organic plant products should not have to adhere to the rules of the pharmaceutical industry because their products are all completely natural and contain no added chemicals. There must be a full testing and labelling process put in place and all companies must adhere to registering with the Scottish Industrial Cannabis Association, who will have very strict guidelines that all business must follow. SICA will commit to liaising with the Scottish Government with full disclosure from both ends guaranteed always to ensure it runs with as little disruption as possible.